U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 08 April 2004

In the Matter of:

ELDON K. NEWPORT
Claimant

Case No.: 2002 BLA 400

v.

SAM DAUGHERTY/DAUGHERTY TRUCKING CO.
UNITED STATES FIDELITY & GUARANTY
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Ron Carson, Personal Representative
For Claimant

Mr. Herbert Williams, Attorney
For Respondent

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER
APPROVAL OF MODIFICATION REQUEST
AWARD OF BENEFITS

This matter involves a claim filed by Mr. Eldon Kenneth Newport for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Administrative Hearing
First Administrative Law Judge Decision

Mr. Newport filed his application for Black Lung disability benefits on October 15, 1990 (DX 1).[1] After considering various medical submissions and conducting a formal conference, the District Director, U.S. Department of Labor ("DOL"), denied Mr. Newport's claim on October 11, 1991 (DX 36). Although a pulmonary function test indicated Mr. Newport may have a totally disabling respiratory impairment, neither the preponderance of the chest x-rays nor medical opinion established the presence of pneumoconiosis. As a result, the District Director concluded Mr. Newport was not totally disabled due to pneumoconiosis. Mr. Newport appealed and on February 5, 1992, the District Director forwarded the claim to the Office of Administrative Law Judges ("OALJ") for a hearing (DX 42 and DX 43). Following a couple of continuances, Administrative Law Judge E. Earl Thomas conducted a hearing on December 16, 1993 (DX 105). On May 10, 1994, Judge Thomas denied Mr. Newport's claim for failure to prove the presence of pneumoconiosis (DX 106).

First Modification Request
Second Administrative Law Judge Decision

On June 7, 1994, Mr. Newport filed a petition for modification and attached another chest x-ray interpretation (DX 107). On March 20, 1995, the District Director denied the modification request since the new evidence did not establish the presence of pneumoconiosis (DX 116). Mr. Newport appealed the adverse decision on March 31, 1995 (DX 117) and the District Director again forwarded the case to OALJ on June 30, 1995 (DX 118). After a determination was made that only a decision on the record would be rendered (DX 121), Administrative Law Judge Jeffrey Tureck denied the request for modification on February 21, 1996 (DX 124). After again finding that the preponderance of the chest x-ray evidence was negative for pneumoconiosis, Judge Tureck also gave Dr. Robinette's medical opinion little probative weight since he seemed to rely on a positive chest x-ray for his diagnosis. As a result, Judge Tureck concluded Mr. Newport demonstrated neither a mistake of fact in, nor a change in condition since, Judge Thomas' denial of his claim (DX 124).

First Benefits Review Board Decision

On March 26, 1996, Mr. Newport appealed Judge Tureck's denial of his modification request to the Benefits Review Board ("Board" and "BRB") (DX 126). On November 26, 1996, the Board vacated Judge Tureck's findings concerning Dr. Robinette's medical report and remanded the case to him for re-evaluation of the medical evidence (DX 131).

[1]The following notations appear in this decision to identify evidence: DX – Director's exhibit; CX – Claimant's exhibit; EX – Employer's exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

Third Administrative Law Judge Decision

On February 28, 1997, Judge Tureck again evaluated the chest x-ray evidence and medical opinion. He concluded Dr. Robinette's diagnosis relied solely on a positive chest x-ray interpretation that was inconsistent with his findings that the radiographic evidence was negative for pneumoconiosis. As a result, Judge Tureck again denied Mr. Newport's claim and modification request because he still failed to prove pneumoconiosis (DX 133). On March 17, 1997, Mr. Newport submitted another appeal (DX 134).

Second Modification Request
Second Benefits Review Board Decision
Second Administrative Hearing
Fourth Administrative Law Judge Decision

While his appeal was pending before the BRB, Mr. Newport submitted new medical evidence to the District Director on May 26, 1997 (DX 136). As a result, the Board dismissed the appeal without prejudice on June 10, 1997 and remanded the claim to the District Director (DX 137). On October 8, 1997, although Mr. Newport provided evidence demonstrating a total respiratory impairment, the District Director concluded the evidence still did not show the presence of coal workers pneumoconiosis (DX 142). Consequently, he denied the modification request. Mr. Newport submitted his appeal on October 23, 1997 (DX 144) and the District Director forwarded the claim to OALJ on January 5, 1998 (DX 145). Due to the modification request, Judge Tureck conducted a hearing on October 8, 1998 (DX 150). On June 9, 1999, after noting that he closed the evidentiary record as of November 30, 1998, Judge Tureck denied the modification request essentially because Mr. Newport failed to prove the presence of pneumoconiosis (DX 158). Specifically, Judge Tureck concluded the new medical opinion by Dr. Sullivan was insufficient proof for three reasons. First, "Dr. Sullivan did not explain the basis of his diagnosis of pneumoconiosis." Second, Dr. Sullivan "also failed to explain" why a year and a half elapsed in his treatment of Mr. Newport before he added coal workers' pneumoconiosis as a diagnosis. Third, his diagnosis of pneumoconiosis was equivocal. On June 15, 1999, Mr. Newport appealed this denial to the BRB (DX 159).

Third Benefits Review Board Decision

On June 16, 2000, the BRB affirmed Judge Tureck's denial of benefits because the evidence did not establish the presence of pneumoconiosis (DX 162). In particular, the Board upheld Judge Tureck's determination that Dr. Sullivan's opinion was insufficient to support a finding of pneumoconiosis because the physician was equivocal and "did not provide an adequate explanation for his diagnosis of pneumoconiosis."

First Reconsideration Request
Fourth Benefits Review Board Decision
Second Reconsideration Request
Fifth Benefits Review Board Decision

On July 10, 2000, Mr. Newport filed a request for reconsideration with the BRB (DX 163) The BRB denied the request on September 27, 2000 (DX 165). Mr. Newport filed a second petition for reconsideration with the BRB, which the BRB again denied on December 20, 2000 (DX 166 and DX 168).

Third Modification Request
Third Administrative Hearing

On January 22, 2001, Mr. Newport submitted new medical evidence with his third petition for modification (DX 169). On May 13, 2002, the District Director denied the request for modification (DX 188). Mr. Newport requested a hearing (DX 189), and the case was forwarded to OALJ on July 24, 2002 (DX 190). After one continuance (ALJ I), I eventually conducted a hearing in Knoxville, Tennessee on March 26, 2003, attended by Mr. Newport, Mr. Carson, and Mr. Williams.

Evidentiary Comment

At the close of the March 2003 hearing, I kept the record open solely for receipt of post-hearing evidence from the Employer in response to the Claimant's late noticed-submission of additional medical evidence (CX 1 to CX 15). In May 2003, I received the Employer's response and now admit Dr. Wheeler's interpretations of x-rays dated November 12, 2002 and February 13, 2003 as EX 3. Additionally, I admit Dr. Fino's medical record review as EX 4. My decision in this case is based on the hearing testimony and the documents admitted into evidence (DX 1 to DX 190, CX 1 to CX 15 and EX 1 to EX 4).

ISSUES

1. Length of coal mine employment.

2. Whether the Benefits Review Board's June 16, 2000 affirmation of Administrative Law Judge Jeffrey Tureck's June 9, 1999 denial of Mr. Newport's second modification request of May 1996 should be modified due to a change in condition or a mistake in determination of fact.

3. If Mr. Newport establishes either a change in condition or a mistake of fact, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: 1) Mr. Newport was a coal miner with post-1969 coal mine employment; 2) Mrs. Geneva Newport is a dependent for the purpose of augmenting any benefits that may be payable; and, 3) Sam Daugherty Trucking is the responsible operator (TR, pages 9 and 10).

Preliminary Findings

Born on November 13, 1931, Mr. Newport married Mrs. Geneva Newport on July 9, 1956 (DX 7). Mr. Newport started hauling coal in 1962. His last coal mine employment occurred in 1990 when the company shut down their operations in LaFollette, Tennessee. At that time, and for almost all of his coal mine employment, Mr. Newport drove a Mack truck carrying coal. Typically, after the coal was loaded onto his truck by a conveyor belt at the mine site, he drove three to four miles to the coal preparation plant where he unloaded the coal for washing. Driving the truck was not physically difficult. However, on occasion, Mr. Newport would have to change a flat tire. Because the truck tire was large and weighed between 150 to 200 pounds, two men were necessary to replace the tire. At other times, in cold weather, Mr. Newport would have to clear the truck bed of frozen coal. That task required him to shovel three to four hundred pounds of coal. Based on Mr. Newport's description of this additional driving-related work, I find his job as a coal truck driver required periodic heavy labor. After leaving coal mining, Mr. Newport was employed for a while as a truck driver, hauling gravel. (DX 1, DX 5, DX 105 (pages 29 to 31, 49 to 52, 54, 56 and 57), and TR, pages 25 to 28).

Mr. Newport first experienced some trouble breathing in 1988 when he sought medical attention. The physician treated Mr. Newport with inhalers, pills and nebulizer breathing treatments. Since December 2002, Mr. Newport has used supplemental oxygen when he sleeps and takes trips outside of his home. He also uses inhalers and pills to aid his breathing. Mr. Newport smoked about 30 years, until 1988. As a smoker, Mr. Newport smoked about a pack a day. (TR, pages 28 to 30, and 32 to 34).

Issue # 1 – Length of Coal Mine Employment

While counsel for the Employer appeared willing to stipulate that Mr. Newport had at least 23 years of coal mine employment, Mr. Newport claims to have about 28 years of coal mine employment (TR, page 9). In his decision, Judge Thomas determined Mr. Newport had 28 years of coal mine employment because, as partially established by Social Security Administration ("SSA") earnings records, Mr. Newport started working at coal mines in 1962 and stopped in 1990 (DX 106). As set out below, my review of the record does not disclose any significant mistake of fact in Judge Thomas' determination.

According to 20 C.F.R. § 718.301 (2001),[2] the length of coal mine employment is calculated in accordance with 20 C.F.R. § 725.101(a) (32) (2001). In turn, 20 C.F.R. § 725.101 (a) (32) (2001) defines a "year" of coal mine employment as a calendar year consisting of either 365 or 366 days, or partial periods totaling one year, during which a miner worked in and around a coal mine for at least 125 working (paid) days. As a result, if a miner worked at least 125 days in a calendar year or "partial periods totaling one year," then he is given credit for one year of coal mine employment.

Next, with that definition of a year in place, the regulation sets out two procedures for determining length of coal mine employment. First, if the beginning and ending dates of coal mine employment can be ascertained and that time period spans a calendar year, then the miner receives credit for one year of coal mine employment. In that case, the regulation presumes the miner worked at least 125 days during that calendar year. 20 C.F.R. § 725.101 (a) (32) (ii) (2001).

Second, if the evidence is insufficient to determine the beginning and ending dates of employment, or the employment covered less than a calendar year, 20 C.F.R. § 725.101 (a) (32) (iii) (2001) sets out a somewhat complicated process to determine length of coal mine employment. First, the miner's yearly income is divided by the coal mine industry's average daily earnings for that year, as reported by the Bureau of Labor Statistics ("BLS"). The product of that calculation represents the number of "work" days. Next, the number of "work" days is divided by 125 to establish a "fractional" year of coal mine employment. 20 C.F.R. § 725.101 (a) (32) (i) (2001). Finally, the fractional portions are added to determine the length of coal mine employment.

Based on a combination of Mr. Newport's testimony (DX 105, pages 43 to 47), his other submissions, including pay stubs (DX 2, DX 6 and DX 32), and SSA earning records (DX 3), I am able to determine the beginning and ending dates of Mr. Newport's coal mine employment and find that he has a total of just over 27 years of coal mine employment as follows:

Company	**Dates**	**Months**	**Cumulative Total**
Daughtery Trucking	March 1962 – March 1966	49	4 years, 1 month
Hurricane Mountain Coal	February 1967 – April 1967	3	4 years, 4 months
Daughtery Trucking	April 1967 – March 1975	96	12 years, 4 months
Long Pit Coal	March 1975 – September 1979	55	16 years, 11 months
Pioneer Coal	September 1979 – December 1981	28	19 years, 3 months
Daughtery Trucking	September 1982 – July 1990	95	27 years, 2 months

Issue # 2 - Modification

Any party to a proceeding may request modification at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. § 725.310 (a). Upon the showing of a "change in conditions" or a "mistake in a determination of fact," the terms of an award or the decision to deny benefits may be

[2]In January 2001, a new set of DOL regulations concerning the adjudication of black lung claims became effective. Only some portions of the new regulations are applicable to Mr. Newport's claim since it was pending as of January 2001; such applicable provisions will be designated with "(2001)" as a suffix. (*see* 20 C.F.R. § 725.2 (c) (2001)).

reconsidered. An order issued at the conclusion of a modification proceeding may terminate, continue, reinstate, increase or decrease benefit payments or award benefits.

According to the courts and BRB, the phrase "change in conditions" refers to a change in a claimant's physical condition. *See General Dynamics Corp. v. Director,* OWCP, 673 F.2d 23 (1st Cir. 1982) and *Lukman v. Director,* OWCP, 11 B.L.R. 1-71 (1988) (*Lukman II*). Under the regulatory provisions, to determine whether a claimant demonstrates a change in conditions, an administrative law judge ("ALJ") must first conduct an independent assessment of all newly submitted evidence. Then, the ALJ must consider this new evidence in conjunction with all evidence in the official U.S. Department of Labor record to determine if the weight of the evidence is sufficient to establish an element of entitlement which was previously adjudicated against the claimant. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993); *Kovac v. BCNR Mining Corp*., 14 B.L.R. 1-156 (1990), *aff'd. on reconsideration*, 16 B.L.R. 1-71 (1992).

The modification process has been further expanded by the United States Supreme Court and federal Courts of Appeals when they considered cases involving the mistake of fact factor listed in the regulations. In *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971), the United States Supreme Court indicated that an ALJ should review all evidence of record to determine if the original decision contained a mistake in a determination of fact. In considering a motion for modification, the ALJ is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *See also Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993); *Director, OWCP v. Drummond Coal Co. (Cornelius)*, 831 F.2d 240 (11th Cir. 1987).

My determination of whether either a change in condition has developed or a mistake of fact occurred involves the four entitlement elements that a claimant must prove by a preponderance of the evidence to receive benefits under the Act. First, the coal miner must establish the presence of pneumoconiosis.[3] Second, if a determination has been made that a coal miner has pneumoconiosis, it must be determined whether the coal miner's pneumoconiosis arose, at least in part, out of coal mine employment.[4] If a coal miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.[5] Otherwise, the claimant must provide competent evidence to establish the relationship between pneumoconiosis and coal mine employment.[6] Third, the coal miner must demonstrate total respiratory disability.[7] Fourth, the coal miner must prove the total disability is due to coal workers' pneumoconiosis.[8]

[3] 20 C.F.R. §718.202 (2001).

[4] 20 C.F.R. §718.203 (a) (2001).

[5] 20 C.F.R. §718.203 (b) (2001).

[6] 20 C.F.R. §718.203 (c) (2001).

[7] 20 C.F.R. §718.204 (a) (2001).

In his denial of Mr. Newport's second request for modification, Judge Tureck determined that Mr. Newport could not establish grounds for modification or entitlement to benefits because the evidentiary record, which closed November 30, 1998, did not establish the presence of pneumoconiosis. Subsequently, the BRB affirmed that determination. In light of those findings, I will evaluate whether Mr. Newport is able to demonstrate a change in conditions through new evidence developed since November 30, 1998 by showing he now has pneumoconiosis. Secondly, if necessary, I will consider the entire evidentiary record to determine whether a mistake of fact has occurred in the determination of the pneumoconiosis issue.

Change in Condition

Under the change of conditions analysis, I must examine the medical evidence presented since Judge Tureck closed the record of his proceeding on November 30, 1998 to determine whether Mr. Newport has developed pneumoconiosis

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[9] The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[10] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[11] As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202 (2001), the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)) (2001), autopsy or biopsy report (§ 718.202 (a)(2) (2001)), regulatory presumption (§ 718.202 (a)(3) (2001)),[12] and medical opinion (§ 718.202 (a)(4) (2001)). Since the record does not contain evidence that Mr. Newport has complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory

---

[8] 20 C.F.R. §718.204 (a) (2001).
[9] 20 C.F.R. § 718.201 (a) (2001).

[10] 20 C.F.R. §§ 718.201 (a)(1) and (2) (2001).

[11] 20 C.F.R. § 718.201 (b) (2001).

[12] If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3) (2001), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (2001) (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (2001) (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (2001) (a presumption when a survivor files a claim prior to June 30, 1982).

presumption of pneumoconiosis is not applicable. In addition, he has not submitted a biopsy report and the record obviously does not contain an autopsy report. As a result, Mr. Newport will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis.

Chest X-Rays[13]

The following table summarizes the newly submitted chest x-ray interpretations:

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
Nov. 24, 2000	DX 180	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD (chronic obstructive pulmonary disease) present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 175	Dr. Baker, B	Positive for pneumoconiosis, profusion category 1/0,[14] type s/t opacities.[15]
(same)	DX 187 & EX 2	Dr. Fino, B	Negative for pneumoconiosis. Bilateral lower lobe pulmonary fibrosis present.
March 13, 2001	CX 8	Dr. Sullivan	Hyper inflation. Increased nodularity.
March 29, 2001	CX 8	Dr. Sullivan	Increased markings in right base.
April 12, 2001	CX 8	Dr. Sullivan	Increased markings
(same)	DX 187 & EX 2	Dr. Fino, B	Negative for pneumoconiosis. Bilateral lower lobe pulmonary fibrosis.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis, emphysema and bullae present.
Sept 4, 2001	CX 8	Dr. Sullivan	Increased markings, pulmonary nodules of moderate perfusion.

[13]On April 2, 2002, Dr. Sullivan stated, "Today's chest x-ray as far as I can tell is essentially unchanged." Since that chest x-ray is not actually in the record and Dr. Sullivan provided no other interpretation regarding it, I have not included his comment about the x-ray.

[14]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102 (b) (2001), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

[15]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

(same)	DX 187 & EX 2	Dr. Fino, B	Negative for pneumoconiosis. Bilateral lower lobe pulmonary fibrosis present
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 185	Dr. Sargent, B, BCR	Negative for pneumoconiosis, profusion category 0/1, type s opacities. Possible emphysema present.
Oct. 4, 2001	DX 187 & EX 2	Dr. Fino, B	Negative for pneumoconiosis. Bilateral lower lobe pulmonary fibrosis.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 186	Dr. Sargent, B, BCR	Negative for pneumoconiosis, profusion category 0/1, type s/s opacities.
Jan. 21,2002	CX 8	Dr. Sullivan	Slight increased markings, right lower lobe.
Nov. 12, 2002	CX 4 & and CX 5	Dr. Ahmed, B, BCR	Positive for pneumoconiosis, profusion category 1/1, type t/s opacities. Emphysema and bullae also present
(same)	EX 3	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema present.
Feb. 13, 2003	CX 3 & CX 5	Dr. Ahmed, B, BCR	Positive for pneumoconiosis, profusion category 1/1, type s/p opacities. Emphysema and bullae present.
(same)	EX 3	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and pleural thickening present.
Feb. 19, 2003	CX 6 & CX 7	Dr. Baker, B	Positive for pneumoconiosis, profusion category1/0, type t/p opacities. Emphysema present
(same)	EX 3	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and pleural thickening present.

Of the ten chest x-rays developed since October 1998, the experts who reviewed two of the films agree they are insufficient for a diagnosis of pneumoconiosis. First, based on the consensus of Dr. Fino, Dr. Wheeler, and Dr. Sargent, the October 4, 2001 chest x-ray is negative for pneumoconiosis. Second, turning to Dr. Sullivan's sole interpretations of the March 13, 2001, March 29, 2001, and January 21, 2002 chest x-rays, his noted observations are insufficient to support a finding of pneumoconiosis.

Dr. Sullivan's interpretation of the April 12, 2001 chest x-ray also does not establish the presence of pneumoconiosis because he failed to specify the nature and extent of the increased markings under ILO standards. Additionally, his finding is outweighed by the opinions of Dr. Wheeler and Dr. Fino that the chest x-ray is negative for pneumoconiosis. For the same reasons, Dr. Sullivan's interpretation of the September 4, 2001 chest x-ray is outweighed by the consensus of Dr. Fino, Dr. Wheeler, and Dr. Sargent that the film is negative. As a result, I find the April 12, 2001 and September 4, 2001 chest x-rays are negative for pneumoconiosis.

The four physicians who reviewed the November 24, 2000 chest x-ray disagreed on its contents. Dr. Baker, a B reader, diagnosed pneumoconiosis. Dr. Wiot and Dr. Wheeler, both dual qualified radiologists, believed the film was negative for pneumoconiosis. Dr. Fino agreed with the radiologists. Based on their superior qualifications, I give the assessments of Dr. Wiot and Dr. Wheeler greater probative value. As a result, the preponderance of the more probative opinion establishes that the November 24, 2000 chest x-ray is negative for pneumoconiosis.

Dr. Ahmed and Dr. Wheeler, both dual qualified radiologists, looked at the November 12, 2002 and February 13, 2003 chest x-rays and reached starkly different conclusions. Dr. Ahmed saw sufficient opacities for a diagnosis of pneumoconiosis. In contrast, Dr. Wheeler observed no such opacities. Since both of these physicians are equally well qualified, their medical opinion disagreement represents an evidentiary draw. Consequently, I am unable to ascertain whether these two chest x-rays establish the presence of pneumoconiosis.[16]

Finally, Dr. Baker, a B reader, diagnosed pneumoconiosis based on his review of the February 19, 2003 chest x-ray. Dr. Wheeler, a dual qualified radiologist found the film negative for pneumoconiosis. Since Dr. Wheeler is better qualified to evaluate chest x-rays, I give his assessment greater probative weight and find that the February 19, 2003 chest x-ray is negative for pneumoconiosis.

In summary, the newly developed radiographic evidence is either negative, inconclusive or insufficient to establish the presence of pneumoconiosis. Consequently, Mr. Newport is not able to prove by chest x-ray evidence that he has developed pneumoconiosis since the record closed on the proceedings before Judge Tureck in November 1998.

One additional comment is warranted in regards to the chest x-ray evidence. Nearly every physician who evaluated Mr. Newport's recent chest films, including Dr. Baker and Dr. Ahmed, found evidence of emphysema or COPD.

Medical Opinion

Although Mr. Newport is unable to demonstrate the presence of pneumoconiosis through the preponderance of the new chest x-ray evidence, he may still establish a change in condition through the preponderance of the more probative medical opinion. To place the various medical opinions into perspective and assist in understanding the documentation utilized by various doctors in reaching their conclusions, I will review the additional objective medical tests that have been administered to Mr. Newport since November 1998.

[16]On May 2, 2003, Dr. Wheeler stated he disagreed with Dr. Ahmed's positive interpretation for pneumoconiosis because Dr. Ahmed had previously identified the opacities on Mr. Newport's lungs as type t/s, but in the February 13, 2003 film, he found type s/p opacities. However, type s and t opacities are not typically related to coal workers' pneumoconiosis. As a result, Dr. Wheeler discounted the physician's findings. Although Dr. Wheeler's comments provide additional background to the chest x-rays, the ILO chest x-ray form includes type s and t opacities as abnormalities consistent with pneumoconiosis. As a result, Dr. Ahmed's opacity findings on the ILO form do not by themselves impeach his finding of pneumoconiosis.

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV_1 pre[17] post[18]	FVC pre Post	MVV pre post	% FEV_1 / FVC pre post	Qualified[19] pre Post	Comments
DX 176	Jan. 19, 2001[20] Dr. Baker	69 67″	1.35	2.97		45	Yes[21]	Valid per Dr. Michos (DX 176)
DX 177	Mar. 13, 2001 Dr. Sullivan	69 68″	1.26	2.92		43	Yes[22]	Valid per Dr. Michos (DX 177)
DX 175 & DX 176	April 27, 2001 Dr. Baker	69 67″	1.39	3.65		38	Yes[23]	Moderate obstruction. Valid per Dr. Michos (DX 176)
CX 9	May 13, 2002 Dr. Sullivan	70 68″	1.36	3.13		43	Yes[24]	Severe obstruction/ reduction of diffusion
CX 6	Feb. 19, 2003 Dr. Baker	71 67.25″	1.33	3.09		43	Yes[25]	Moderate obstructive defect
CX 1	Feb. 20, 2003	71	1.17	2.78	50.5	42	Yes[26]	Severe

[17]Test result before administration of a bronchodilator.

[18]Test result following administration of a bronchodilator.

[19]Under 20 C.F.R. § 718.204 (b)(2)(i) (2001), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), **and either** the FVC has to be equal or less than the value in Table B3, **or** the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[20]Because this test was conducted on or after January 19, 2001, the flow-volume loop is required to be admitted into the record. 20 C.F.R. §718.103(b) (2001).

[21]The qualifying FEV_1 number is 1.66 for age 69 and 66.9″; the corresponding qualifying FVC and MVV values are 2.15 and 67, respectively.

[22]The qualifying FEV_1 number is 1.76 for age 69 and 68.1″; the corresponding qualifying FVC and MVV values are 2.27 and 70, respectively.

[23] The qualifying FEV_1 number is 1.70 for age 69 and 67.3″; the corresponding qualifying FVC and MVV values are 2.18 and 67, respectively.

[24]The qualifying FEV_1 number is 1.74 for age 70 and 68.1″; the corresponding qualifying FVC and MVV values are 2.25 and 70, respectively.

[25]The qualifying FEV_1 number is 1.66 for age 71 and 67.3″; the corresponding qualifying FVC and MVV values are 2.16 and 67, respectively.

	Dr. Narayanan	69″						obstruction

Arterial Blood Gas Study

Exhibit	Date / Doctor	pCO_2 (rest) pCO_2 (exercise)	pO_2 (rest) pO_2 (exercise)	Qualified[27]	Comments
CX 6	Feb. 19, 2003 Dr. Baker	39	72	No[28]	

CT Scans

A January 2002 CT scan reveals the development of another pulmonary nodule in Mr. Newport's lung.[29]

Dr. Kenneth Rule reviewed a CT scan from August 22, 2002 and noted the presence of two, stable pulmonary nodules and severe emphysema.[30]

Dr. William Pflanze read a CT scan taken on December 23, 2002 and compared the imaging with two previous CT scans taken in January and May 2002. Since the small nodule in the right upper lung lobe was unchanged, Dr. Pflanze believed it was probably calcified and benign. Two other small, but less defined, nodules were also stable. The physician also found severe emphysematous changes throughout both lungs (CX 12).

Physician Evaluations

Dr. Thomas A. Sullivan, Jr.
(DX 140, DX 148, DX 149, DX 150, DX 158, DX 174, DX 181, CX 8, CX9, CX 13, and CX 15)[31]

From March 1997 through February 2003, Dr. Sullivan, board certified in internal medicine and pulmonary disease, treated Mr. Newport's pulmonary condition. Mr. Newport had a 28 to 29 year coal mine employment history and a cigarette smoking history that spanned 25 years, ended in 1988 and involved the consumption of one and a half cigarettes per day. Mr.

---

[26]The qualifying FEV_1 number is 1.79 for age 71 and 68.9″; the corresponding qualifying FVC and MVV values are 2.31 and 72, respectively.

[27]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO_2 level, the value of the coal miner's pO_2 must be equal to or less than corresponding pO_2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[28]For the pCO_2 of 39, the qualifying pO_2 is 61, or less.

[29]The result of this CT scan was reported by Dr. Sullivan in his April 2, 2002 office note (CX 8).

[30]The result of this CT scan was reported by Dr. Sullivan in his August 27, 2002 office note (CX 8).

[31]Although some of Dr. Sullivan's evaluations predate the November 1998 record closure date, I have included all his observations to better understand the basis for his present conclusions.

Newport presented with shortness of breath. In January 1997, x-rays revealed marked hyperinflation and the presence of nodules. A pulmonary function test showed a severe obstruction with some mild improvement post bronchodilation. Dr. Sullivan diagnosed chronic obstructive lung disease, emphysema and possible chronic bronchitis. Again, in March 1997, Dr. Sullivan made the same diagnoses and considered possible asbestos exposure. In June 1997, Dr. Sullivan found increased markings on the chest x-ray and continued to diagnose chronic obstructive bronchitis and emphysema.

In February 1998, Dr. Sullivan diagnosed a cough with pleuritic chest pain, possible respiratory inflammation and bronchitis based on fibrotic changes and increased markings that he read on the x-ray. In June 1998, Dr. Sullivan again diagnosed chronic obstructive bronchitis and emphysema.

In July 1998, finding slight increased markings on the x-ray, Dr. Sullivan diagnosed acute bronchitis with chronic obstructive bronchitis and coal workers' pneumoconiosis. When Dr. Sullivan treated Mr. Newport in August 1998, he noted that Mr. Newport presented with a history of coal workers' pneumoconiosis. Subsequently, in October 1998, Dr. Sullivan wrote a support letter in which he opined that the history of x-rays and physical findings were consistent with pneumoconiosis.

Dr. Sullivan examined Mr. Newport on February 13, 2001. Dr. Sullivan reported that Mr. Newport had worked in a coal mine and possibly had coal workers' pneumoconiosis. He used to smoke but stopped in 1988. He has a history of some bronchitis. Upon physical examination, Dr. Sullivan found fair air exchange and no wheezes or rales. The physician concluded that Mr. Newport had chronic obstructive bronchitis, coal workers' pneumoconiosis, and a pulmonary nodule of uncertain etiology.

On March 13, 2001, Dr. Sullivan examined Mr. Newport who complained of increased shortness of breath and chest congestion. Mr. Newport's other pulmonary conditions included coal workers' pneumoconiosis and chronic bronchitis. Dr. Sullivan described Mr. Newport's 30 year history as a coal truck operator which was a dusty job. He had also been a cigarette smoker who stopped in 1988. During the physical examination of Mr. Newport's chest, Dr. Sullivan found basilar rhonchi and poor air exchange. Based on his review of the x-ray, Dr. Sullivan noted hyperinflation of the lungs. His review of the pulmonary function test showed severe reduction of the FEV_1, consistent with severe obstruction and severe oxygen diffusing capacity. Dr. Sullivan's diagnosis included "probable acute bronchitis superimposed on coal workers' pneumoconiosis" and emphysema.

On March 29, 2001, Dr. Sullivan examined Mr. Newport, noting increased shortness of breath, poor air exchange and the presence of faint rhonchi and rales, more prevalent on the right side than the left. The chest x-ray showed increased markings in the right base. The physician diagnosed acute exacerbation of chronic bronchitis, emphysema, and coal workers' pneumoconiosis.

On April 12, 2001, Dr. Sullivan conducted a two week follow-up of Mr. Newport's pulmonary condition. He noted poor air exchange and scattered rhonchi. The chest x-ray

showed increased markings. Dr. Sullivan diagnosed acute bronchitis, acute exacerbation of chronic bronchitis, emphysema, pulmonary fibrosis, and coal workers' pneumoconiosis.

On September 4, 2001, Dr. Sullivan conducted a follow-on examination of Mr. Newport who was suffering from chronic obstructive bronchitis, coal workers' pneumoconiosis, emphysema, and a stable pulmonary nodule. After commenting on Mr. Newport's coal mine employment and cigarette smoking history, Dr. Sullivan reported that upon physical examination of the chest, he heard decreased breath sounds. A chest x-ray showed increased markings and pulmonary nodules of moderate perfusion. Dr. Sullivan continued to diagnose acute bronchitis, coal workers' pneumoconiosis, and chronic obstructive bronchitis.

Also on September 4, 2001, Dr. Sullivan summarized his assessment of Mr. Newport's pulmonary condition. Mr. Newport had been a heavy cigarette user, smoking up to a pack and a half a day until 1988. Also, as a coal miner and truck driver, he had been exposed to coal dust for 28 and 1/2 years. Additionally, Mr. Newport had not been exposed to asbestos. No tuberculosis exposure was noted. Through chest x-rays, small pulmonary nodules had been identified. Pulmonary function studies disclosed severe obstruction with hyperinflation and reduction of carbon monoxide diffusion capability. Dr. Sullivan's initial diagnosis included chronic obstructive bronchitis, possible emphysema, possible asthmatic bronchitis," and "possible component of coal workers pneumoconiosis." Since his first treatment with Dr. Sullivan in 1997, Mr. Newport had "done relatively well," with only occasional medication for acute exacerbation of his pulmonary problems. A more recent pulmonary function test revealed severe obstruction with normal total lung capacity and moderately severe reduction in his carbon monoxide diffusion capacity. In the most recent physical examination, Dr. Sullivan noted hyperinflation, poor air exchange with a few scattered rhonchi from time to time. The physician diagnosed severe obstructive airway disease, attributed to a few factors, "one certainly has been his exposure to coal dust for a 20 year period." Dr. Sullivan believed that exposure was "probably" responsible for the noted pulmonary nodules. In part due to his pulmonary conditions, Mr. Newport is totally disabled. Dr. Sullivan intended to provide therapy for Mr. Newport's exacerbation of his bronchitis.

On January 21, 2002, Dr. Sullivan examined Mr. Newport to follow his stable pulmonary nodule. The physician found "pretty good" air exchange, but an occasional rale." He diagnosed chronic obstructive bronchitis, emphysema and coal workers' pneumoconiosis.

On April 2, 2002, Dr. Sullivan examined Mr. Newport, noting the presence of a few rhonchi upon physical exam of the patient's chest. Dr. Sullivan diagnosed chronic bronchitis, emphysema and a history of coal workers' pneumoconiosis with the presence of pulmonary nodules, including a new one established by a January 2002 CT scan.

On May 13, 2002, Dr. Sullivan conducted another office exam of Mr. Newport, a retired coal miner and former cigarette smoker. A recent CT scan had established that the right lung nodule was "calcified on thin collimation." The imaging also found severe emphysema. Mr. Newport's exertional capacity was fair, but he experienced shortness of breath with exercise. Upon physical exam, Dr. Sullivan found fair air exchange in the lungs. Dr. Sullivan diagnosed

chronic obstructive bronchitis, "probably" related to the emphysema and the presence of a "hopefully calcified" pulmonary nodule.

On August 27, 2002, Dr. Sullivan examined Mr. Newport for observation of a pulmonary nodule which appeared to be stable. Mr. Newport had worked in the coal mines for 20 years and was a heavy cigarette smoker until 1988. An August 22, 2002 CT scan disclosed two stable pulmonary nodules and severe emphysema. A physical exam of the chest showed fair air exchange. He diagnosed Mr. Newport with fairly severe and stable chronic bronchitis and emphysema.

During an office visit on February 3, 2003 for the treatment of a pulmonary nodule, Dr. Sullivan again examined Mr. Newport and found fair air exchange and no wheezes or rales. Mr. Newport, a 20 year coal miner and prior heavy cigarette smoker, was doing fairly well with his emphysema. Dr. Sullivan noted that a CT scan had identified a stable pulmonary nodule. Dr. Sullivan diagnosed chronic bronchitis, emphysema, and exertional dyspnea.

Dr. Glen R. Baker, Jr.
(DX 174, DX 181, CX 6, CX 7, and CX 14)

Between November 2000 and March 30, 2001, Dr. Baker, board certified in pulmonary disease and internal medicine, treated Mr. Newport on several occasions for long-term, and worsening, shortness of breath. Mr. Newport had smoked cigarettes for 25 years at the rate of a pack a day. He stopped smoking about 1989. Mr. Newport worked around coal mines for 28 and 1/2 years. He reported no history of asthma or tuberculosis. Mr. Newport came to Dr. Baker on March 30, 2001 with acute exacerbation of his obstructive pulmonary disease. Upon examination, Dr. Baker heard expiratory wheezing and observed severe dyspnea. Dr. Baker believed Mr. Newport has coal workers' pneumoconiosis, category 1/0, and a mild to moderate obstructive defect, as shown by pulmonary function tests.

In August 2001, Dr. Baker explained that he based his diagnosis of coal workers' pneumoconiosis on Mr. Newport's "chest x-ray findings and history." Additionally, due to his cigarette smoking history, Mr. Newport "may have some obstructive airway disease on that basis as well." However, Dr. Baker opined Mr. Newport's "primary breathing trouble is due to his coal workers' pneumoconiosis." Without his exposure to coal dust and associated pneumoconiosis, Mr. Newport's "breathing would not be as disabling as it is."

On November 19, 2002, based on his treatment of Mr. Newport over the course of a couple of years, Dr. Baker summarized this assessment of his pulmonary problems. Mr. Newport had worked in coal mining for over twenty years, with his last job ending in 1990. He had smoked cigarettes for 25 years at the rate of a pack a day and then stopped 13 years ago. Mr. Newport did not have a history of tuberculosis or asthma. Mr. Newport struggled with shortness of breath. His medical treatment included inhalers and antibiotics for exacerbation of his condition. Pulmonary function tests showed a moderate obstruction, radiographic evidence was positive for pneumoconiosis, and physical examination revealed inspiratory and expiratory wheezes. Dr. Baker diagnosed an obstructive airways disease, chronic bronchitis and coal workers' pneumoconiosis. Specifically, he explained:

> Mr. Newport has Coal Workers' Pneumoconiosis, Category 1/0, on basis of 1980 ILO Classification, chronic obstructive airways disease with moderate obstructive ventilatory defect and chronic bronchitis. It is thought that with his long history of coal dust exposure, at least part of his symptoms if not a significant part of his symptoms are related to his coal dust exposure as well as in perhaps equal amount to his cigarette smoking history.

On February 19, 2003, Dr. Baker conducted a pulmonary examination of Mr. Newport. Mr. Newport had worked in the coal mines for 28 ½ years. Mr. Newport had smoked between a pack and a pack and a quarter of cigarettes per day for about 30 years. His presenting complaints included long term shortness of breath with exertion, chronic cough and wheezing. Upon physical examination, Dr. Baker heard decreased breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary function test demonstrated Mr. Newport had a moderate pulmonary obstructive defect. The resting arterial blood gas study indicated mild hypoxemia. Based on the chest x-ray and history of coal mine employment, Dr. Baker diagnosed coal workers' pneumoconiosis. As reflected by the pulmonary function tests, Dr. Baker also diagnosed chronic obstructive pulmonary disease and mild hypoxemia due to cigarette smoke and coal dust exposure Due to all three pulmonary conditions, Mr. Newport no longer retained the respiratory capacity to work in a coal mine or perform comparable work in a dust-free environment.

Dr. Gregory J. Fino
(DX 187, EX 2, and EX 4)

On October 10, 2001, Dr. Gregory Fino, board certified in internal medicine and pulmonary disease, reviewed Mr. Newport's extensive medical records, which included the treatment notes and medical opinions of Dr. Barker and Dr. Sullivan. After evaluating the various medical opinions and test results, Dr. Fino concluded that Mr. Newport did not have coal workers' pneumoconiosis or any other pulmonary condition resulting from coal dust. He based these findings on: a) the majority of chest x-rays which were negative for pneumoconiosis; b) the presence of an obstructive lung disease which was consistent with smoking; and, c) reduced diffusing capacity values that were also consistent with smoking. Mr. Newport was exposed to two risk factors, smoking and coal dust exposure, however Dr. Fino opined that the effects suffered by Mr. Newport are consistent with a smoking disability, not a coal dust induced disease. For the same reason, Dr. Fino believed that Mr. Newport would have the same disability if he had never worked in the mines. The physician concluded that Mr. Newport is totally disabled but his disability is not related to coal dust.

In an October 2002 deposition, Dr. Fino further explained his findings based on his review of the medical record which included multiple chest x-rays, three CT scans, pulmonary function tests, and numerous physician treatment notes. Based on this review, Dr. Fino diagnosed significant COPD with chronic obstructive bronchitis and emphysema. Even though Mr. Newport was confronted with two pulmonary risk factors, 30 to 35 years as a cigarette smoker and 28 years working as a coal truck driver, Dr. Fino concluded Mr. Newport's pulmonary impairment was due solely to his cigarette smoking. He explained that the

abnormalities in Mr. Newport's lungs are not consistent with pneumoconiosis. Specifically, the pulmonary function test results demonstrate that Mr. Newport's obstructive defect is greater in the small airways than in the large ones. This type of lung damage is caused by cigarette smoke and not coal dust. Secondly, the pulmonary function tests showed marked elevation in lung volume in conjunction with the reduction and diffusing capacity, which again is a pulmonary condition consistent with smoking. Additionally, even if coal dust did contribute to Mr. Newport's pulmonary impairment, its contribution is negligible in comparison to the extensive damage caused by cigarette smoke. In summary, considering all the objective medical evidence, Dr. Fino stated Mr. Newport does not have pneumoconiosis and that his lung conditions are not related to his exposure to coal dust.

On May 5, 2003, Dr. Fino conducted a review of additional medical evidence developed in Mr. Newport's case, including recent CT scans, pulmonary function tests and blood gas studies. According to Dr. Fino, this additional review provided no reason for him to change his opinion. He again concluded that Mr. Newport did not have coal workers' pneumoconiosis, but that he is totally disabled from a respiratory standpoint. He does not, however, attribute the disability to coal dust inhalation but rather to Mr. Newport's history of cigarette smoking.

Dr. Paul Wheeler
(EX 1 and EX 3)

Dr. Wheeler, a board-certified radiologist and B reader, reviewed a series of x-rays taken of Mr. Newport between May 16, 1989 and October 4, 2001. The most significant change that he found over the 11 year period was the varying size of Mr. Newport's heart, which was always within normal limits. Considering Mr. Newport's smoking history, which ranged from 20 to 35 years at 1 ½ packs of cigarettes per day, Dr. Wheeler believed that Mr. Newport suffered from emphysema caused by smoking, whether Mr. Newport smoked for 20 or 35 years. Since coal dust does not cause emphysema, he did not attribute the obstructive disease to coal dust exposure; at the same time, he noted the additional irritation does not help. Specifically disagreeing with Dr. Baker's assessment of the April 2001 x-ray, Dr. Wheeler found decreased lung markings rather than increased lung markings, as would typically be present with pneumoconiosis. Dr. Wheeler also stated that the detailed CT scans of Mr. Newport's lungs further established that he suffers from emphysema caused by cigarette smoking. According to Dr. Wheeler, none of Mr. Newport's pulmonary conditions are related to or caused by coal dust exposure.

Dr. Gurpreet Narula
(CX 10, CX 11, CX 12)

On October 30, 2001, Dr. Narula, board certified in internal medicine,[32] treated Mr. Newport for a persistent cough. Mr. Newport's chest was clear and Dr. Narula diagnosed acute bronchitis.

[32]As I informed the parties at the hearing (TR, page 7), I take judicial notice of Dr. Narula's board certification and have attached the certification documentation.

On eleven occasions in 2002, Dr. Narula treated Mr. Newport for a variety of ailments and complaints. The office visits related to pulmonary problems usually involving a persistent cough and shortness of breath. Additionally, one visit occurred in December 2002 because Mr. Newport was unable to breathe at night. Upon physical examination, Dr. Narula typically reported diminished breath sounds and wheezes. Her pulmonary diagnosis was usually acute bronchitis, chronic obstructive pulmonary disease (at times exacerbated), and lung nodules.

On February 10, 2003, Dr. Narula indicated Mr. Newport had severe obstructive pulmonary disease and lung nodules. He had been prescribed home oxygen to aid his breathing. Having closely monitored the lung nodules, Dr. Narula opined the multiple pulmonary nodules were probably calcified granulomas. According to Dr. Narula, Mr. Newport is "quite incapacitated" from a respiratory standpoint with severe dyspnea on exertion.

On February 21, 2003, Dr. Narula again saw Mr. Newport due to a chronic cough and shortness of breath. She heard wheezing in both lungs and diagnosed bronchitis and chronic obstructive pulmonary disease.

On February 24, 2003, Dr. Narula again reported that Mr. Newport had pulmonary nodules, chronic obstructive airway disease and emphysema. As a result, he struggled with severe shortness of breath on exertion and occasionally has a cough. Additionally, an overnight oxygen saturation test revealed Mr. Newport suffered a drop in his oxygen level. A pulmonary function test showed a mild restrictive airways disease. Dr. Nurula stated that because Mr. Newport "worked in the underground coal mines for several years," his coal dust exposure "may have very well contributed to his underlying lung disease along with long years of smoking heavily."

Discussion

According to Dr. Sullivan and Dr. Baker, Mr. Newport has radiographic evidence of coal workers' pneumoconiosis and his obstructive pulmonary impairment is related in part to his exposure to coal dust. Dr. Narula believes there may be a connection between Mr. Newport's coal mine employment and his pulmonary impairment. On the other hand, Dr. Wheeler and Dr. Fino conclude that Mr. Newport's obstructive defect is unrelated to his coal mine employment. To resolve this conflict in medical opinion, I must assess the relative probative value of each respective opinion in terms of documentation and reasoning.

Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co*., 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. *See Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998).

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91 (1988).

With these principles in mind, I give Dr. Narula's opinion little relative probative weight. Although she had a solid documentary basis for her conclusion, Dr. Narula expressed a tentative, rather than definitive conclusion. While her use of the phrase "may very well have contributed" might simply reflect the degree of confidence to which she is willing to express a medical conclusion, her statement can also be read to represent uncertainty over the connection. The characterization of her opinion as equivocal is strengthened considering that in her multiple treatment notes concerning Mr. Newport's pulmonary complaints, Dr. Narula never diagnosed pneumoconiosis.

Dr. Wheeler acknowledged his understanding of the term "legal pneumoconiosis." Nevertheless, as a basis for concluding Mr. Newport's pulmonary condition was not related to coal dust exposure, Dr. Wheeler stated coal dust does not cause emphysema. That observation indicates a focus solely on clinical pneumoconiosis. As previously discussed, the regulations permit a finding of pneumoconiosis based on either clinical or legal pneumoconiosis. Emphysema falls within that later definition if its related to coal mine employment. *Hughes v. Clinchfield Coal Co.*, 21 B.L.R. 1-134, 1-139 (1999).

In terms of documentation, with the one exception discussed immediately below, the remaining opinions of Dr. Fino, Dr. Sullivan and Dr. Baker stand on essentially equal footing. As treating physicians, both Dr. Sullivan and Dr. Baker developed an extensive understanding of Mr. Newport's pulmonary condition through their periodic and long term doctor-patient contacts. Since Dr. Fino reviewed the office and treatment notes of both physicians, he also indirectly[33] obtained the documentary advantage associated with the physicians' care of Mr. Newport. In fact, although not a treating physician, Dr. Fino perhaps had the best documentary basis for his conclusion due to his comprehensive review of Mr. Newport's entire medical record.

The one documentary exception relates to the radiographic evidence in record. Based on his observation, Dr. Baker opined Mr. Newport's chest x-rays contained evidence of pneumoconiosis. Dr. Sullivan also stated that Mr. Newport's history of chest x-rays was consistent with pneumoconiosis. Neither doctor specifically cited any other medical evidence to support their clinical pneumoconiosis diagnosis. Their conclusions about the radiographic documentation conflicts with my determination that the preponderance of the chest x-ray evidence is negative for the presence of pneumoconiosis. Due to my finding, Dr. Baker and Dr. Sullivan relied on incorrect documentation to conclude Mr. Newport has clinical, or medical,

[33]I found no evidence that Dr. Sullivan and Dr. Baker obtained a distinguishable documentary advantage due to their direct contact with Mr. Newport.

pneumoconiosis. Consequently, on the issue of whether Mr. Newport has clinical or medical pneumoconiosis under 20 C.F.R. § 718.201 (a) (1) (2001), their diagnoses have little probative value. In contrast, Dr. Fino's assessment of the radiographic evidence is consistent with my determination. His opinion that Mr. Newport does not have clinical pneumoconiosis is the most probative medical opinion on that issue. Accordingly, I find Mr. Newport is not able to establish the presence of clinical pneumoconiosis through the preponderance of the more probative medical opinion.

Since neither the radiographic evidence nor probative medial opinion establishes the presence of clinical pneumoconiosis, as defined in 20 C.F.R. § 781.201 (a) (1) (2001), Mr. Newport may only show a change in condition if the probative medical opinion establishes the presence of legal pneumoconiosis as defined in 20 C.F.R. §§ 718.201 (a) (2) and (b) (2001). As I began my adjudication of this issue, I came across a court decision that profoundly affects the outcome of that determination. To demonstrate how this singular judicial precedent affects Mr. Newport's case, I first adjudicate this case under the principles that exist outside the jurisdiction of the U.S. Court of Appeals for the Sixth Circuit. Then, in compliance with the judicial precedent established by the court which has jurisdiction over Mr. Newport's claim, I will make my final determination under the principles of the U.S. Court of Appeal for the Sixth Circuit.

A. Adjudication before the BRB and other U.S. Courts of Appeals

By concluding the Mr. Newport's long-term exposure to coal dust contributed to his obstructive impairment, Dr. Sullivan and Dr. Baker also presented a diagnosis of legal pneumoconiosis. In evaluating the merit of that diagnosis before the Benefits Review Board and most U.S. Circuit Courts of Appeal, I would give diminished probative value to the conclusions of Dr. Baker and Dr. Sullivan because neither doctor provided an explanation, or reasoning, for their diagnosis. Dr. Baker and Dr. Sullivan clearly stated the results of the objective medical testing and clinical findings, which established the presence of a chronic obstructive pulmonary impairment. They also highlighted Mr. Newport's previous 25 pack-year[34] plus smoking habit and his 28 years of coal dust exposure (the documentation). However, without any explanation, both doctors concluded that coal dust was a contributing factor to Mr. Newport's pulmonary problem (a diagnosis of legal pneumoconiosis). Notably absent in their opinions is an explanation on how they determined Mr. Newport's exposure to coal dust actually caused or significantly aggravated or contributed to his emphysema. I believe their process of pointing to the pulmonary function test results, clinical findings and Mr. Newport's history of coal mine employment and then declaring a connection represents insufficient, conclusory,[35] or even no, reasoning. Rather than providing any reasoning, Dr. Sullivan and Dr. Baker imply the connection must be obvious.

[34]A pack year represents the consumption of a pack of cigarettes per day for one year.

[35]*See Grundy Mining Co. v. Director, OWCP [Flynn],* 353 F.3d 467, 483 (6th Cir. 2003) ("To the extent that the claimant relies on a physician's opinion . . .such statements cannot be vague or conclusory, but instead must reflect reasoned medical judgment.")

In other words, besides referencing Mr. Newport's history of coal mine employment, neither Dr. Baker nor Dr. Sullivan provided any explanation or rationale on how they were able to distinguish the unique causes of his pulmonary impairment that set his case apart from the etiology of emphysema in the lungs of a prior cigarette smoker who never stepped into a coal mine. The ability to make such a distinction is important since the Black Lung Disability Act does not contain a presumption of pneumoconiosis, even legal pneumoconiosis, based on a history of coal mine employment. Instead, the definition of legal pneumoconiosis requires a connection between the pulmonary condition and coal dust exposure that is both actual and significant. *See Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003) ("[o]nly COPD caused by coal dust constitutes legal pneumoconiosis. *See* 20 C.F.R. § 718.201 (a) (2) (2001). Otherwise, everyone who developed COPD from smoking would have legal pneumoconiosis.")

In contrast, Dr. Fino examined the potential relationship between Mr. Newport's exposure to coal dust and his present obstructive pulmonary impairment. Based on the specific defects identified by the pulmonary function tests, Dr. Fino concluded those test results were inconsistent with a coal dust-related pulmonary obstruction. He explained the obstructive defect in Mr. Newport's small airway passages demonstrated by the pulmonary function test results was consistent with the irritation and damage caused by cigarette smoke rather than coal dust. On that basis, he was able to conclude that Mr. Newport's coal dust exposure did not play any significant role in Mr. Newport's pulmonary impairment. Consequently, as the only documented and reasoned medical opinion on the connection between Mr. Newport's coal dust exposure and his pulmonary condition, I would give Dr. Fino's opinion greater probative weight.

I have considered, as discussed below, that Dr. Fino's explanation might be too focused on clinical pneumoconiosis, and thus of diminished probative value. However, the definition of legal pneumoconiosis requires an actual and significant connection between the pulmonary condition and coal dust exposure. Consequently, an opinion, such as Dr. Fino's assessment, that examines in detail both the nature and extent of that requisite connection is exceptionally probative on the issue of legal pneumoconiosis. Thus, Dr. Fino's detailed medical expert opinion explaining the absence of such a connection based on the objective medical evidence would have greater probative weight than the unexplained, contrary conclusions by Dr. Baker and Dr. Sullivan.[36]

Finally, even if Dr. Sullivan's assessment were deemed to be "reasoned," the seemingly varying nature of his coal workers' pneumoconiosis diagnosis interjects sufficient equivocation to diminish its probative value. As noted by Judge Tureck, during the first year and a half of treating Mr. Newport, Dr. Sullivan did not make a pneumoconiosis diagnosis. Later, when he first diagnosed pneumoconiosis, he stated its existence was "probable." By 2001 and through the spring of 2002, Dr. Sullivan seemed to have become more certain of his view about black lung disease since he typically presented Mr. Newport's pulmonary diagnosis as chronic bronchitis, emphysema and coal workers' pneumoconiosis. However, in the last three treatment notes in the

[36]Likewise, Dr. Narula's opinion would suffer further loss of probative value because, without explanation, she also essentially relied on Mr. Newport's history of coal mine employment as a basis for suggesting the possibility of a connection.

record for May 13, 2002, August 27, 2002, and February 3, 2003, Dr. Sullivan diagnosed only chronic bronchitis and emphysema. He did not mention of coal workers' pneumoconiosis.

In light of the above analysis, before the Benefits Review Board and most U.S Circuit Courts of Appeal, I would find that the preponderance of the more probative medical opinion, represented by Dr. Fino's assessment, does not support a finding that Mr. Newport has legal pneumoconiosis. Additionally, even if Dr. Fino's opinion was determined to be of diminished probative value, the opinions of Dr. Baker, due to the significant reasoning deficiency, and Dr. Sullivan, due to the same lack of reasoning and equivocation, would still fail to establish the presence of legal pneumoconiosis. Consequently, I would have determined that since neither the preponderance of the chest x-ray evidence nor probative medical opinion established the presence of either clinical or legal pneumoconiosis, Mr. Newport failed to prove a change in condition. Likewise, considering all the evidence in the record, I would not have found a mistake of fact in the prior adjudication. Accordingly, I would have denied Mr. Newport's modification request.

B. Adjudication before the U.S. Court of Appeals for the Sixth Circuit

Because Mr. Newport last drove a coal mine truck in Tennessee, his claim for black lung disability falls within the jurisdiction of the U.S. Court of Appeals for the Sixth Circuit. That fact changes the outcome of my decision based on the court's adjudication principles presented in *Cornett v. Benham Coal Co., Inc.* 227 F.3d 569 (2000). Due to the significant impact of the court's decision on Mr. Newport's claim, a detailed review of the *Cornett* decision is warranted.

Mr. Cornett had mined coal for 23 and 1/2 years and smoked half a pack of cigarettes a day for the same period of time. Two examining physicians, Dr. Baker and Dr. Vaezy, diagnosed coal workers' pneumoconiosis (by chest x-ray). While stating they were unable to quantify the extent cigarette smoke contributed to Mr. Cornett's pulmonary condition, both physicians also opined his long-term exposure to coal dust was a "significant" factor in Mr. Cornett's COPD. Another two examining physicians, Dr. Broudy and Dr. Dahhan, disagreed. Dr. Broudy opined Mr. Cornett's chronic bronchitis was due solely to his cigarette smoking and not coal mine employment. Dr. Dahhan found no objective medical evidence to support a diagnosis of an abnormal coal dust-related pulmonary condition. Finally, Dr. Fino, who conducted a medical record review, agreed with Dr. Broudy and Dr. Dahhan, finding Mr. Cornett's condition inconsistent with a pulmonary affliction caused by coal dust.

In his adjudication, the administrative law judge gave little probative weight to the opinions of Dr. Baker and Dr. Vaezy because "[t]hey did not provide support as to why they diagnosed Cornett with pneumoconiosis rather than non-occupational chronic bronchitis" and relied on chest x-ray evidence and Mr. Cornett's history of coal mining. Additionally, the administrative law judge gave greater probative weight to the opinions of Dr. Broudy, Dr. Dahhan, and Dr. Fino. Accordingly, the judge found Mr. Cornett did not prove pneumoconiosis and denied his claim. On appeal, the Benefits Review Board affirmed the administrative law judge's reasoning and denial of benefits.

The U.S. Court of Appeals for the Sixth Circuit reversed the BRB's affirmation and remanded the case to the administrative law judge for additional consideration of the medical evidence. After reviewing the regulatory definition of legal pneumoconiosis, the court determined that the administrative law judge had misstated the basis for Dr. Baker's and Dr. Vaezy's opinions. In addition to the chest x-ray and coal mining history, the court observed that both doctors also considered the results of their examinations, the pulmonary function tests and Mr. Cornett's cigarette smoking history. The court further highlighted that "Dr. Baker went so far as to explain that 'there is sufficient objective and clinical evidence to justify a diagnosis of coal workers' pneumoconiosis notwithstanding a negative x-ray'" (emphasis added). *Id.* at 576. The court next found fault with the administrative law judge's consideration of the opinions of Dr. Broudy, Dr. Dahhan and Dr. Fino. Specifically, in regards to Dr. Broudy and Dr. Dahhan, the court stated

> Drs. Broudy and Dahhan make no attempt to explain on what basis they believe that coal dust exposure did not contribute to Cornett's respiratory problems. By contrast, the opinions of Drs. Vaezy and Baker – which, as noted were discredited by the ALJ (administrative law judge) as having an inadequate basis – clearly address the statutory requirements by acknowledging that coal dust, while not conclusively the cause of Cornett's condition, was certainly an aggravating factor, contributing to Cornett's respiratory impairment (emphasis added).[37] *Id.*, at 576 and 577.

Concerning Dr. Fino's analysis, the court found that his analysis was flawed because his explanation focused on clinical, rather than legal, pneumoconiosis. *Id.* In eliminating coal dust as a possible source of Mr. Cornett's breathing problems, Dr. Fino explained that the pulmonary function test results were inconsistent with the result that would be obtained if fibrosis were present. Because Dr. Fino mentioned "fibrosis," a term "generally associated with 'medical' pneumoconiosis," the court found his explanation was too restrictive because it did not encompass consideration of "legal" pneumoconiosis. *Id.*

With the *Cornett* court's analysis in mind, I return to Mr. Newport's case, which interestingly again places Dr. Baker and Dr. Fino on opposite sides of the pneumoconiosis issue. This time, under the *Cornett* analytical model, I cannot dismiss the opinions of Dr. Baker and Dr Sullivan for being poorly reasoned. Instead, I conclude both doctors presented "reasoned" medical opinions because they stated that the "basis" for their diagnosis of a coal dust-related pulmonary condition included: Mr. Newport's coal mining and cigarette smoking histories, the pulmonary function tests showing a moderate to severe obstructive impairment, and the clinical observations. Since Dr. Baker and Dr. Sullivan provided at least as much "reasoning" as Dr. Baker and Dr. Vaezy in the *Cornett* case, I conclude their diagnoses of legal pneumoconiosis in terms of reasoning are legally sufficient.

[37]If "basis" means the evidence a physician relied upon, all four doctors essentially referenced the same documentation: examination results, pulmonary function tests, smoking history and coal mine employment history. If "basis" means reasoning, all four physicians, Dr. Broudy, Dr. Dahhan, Dr. Baker and Dr. Vaezy, failed to provide any explanation that integrated their conclusions with the objective medical evidence. Only Dr. Fino attempted to provide a basis, or explanation, for concluding no connection existed between Mr. Cornett's coal dust exposure and his breathing problems.

Similarly, based on the court's reasoning in *Cornett*, I conclude Dr. Fino's opinion has diminished probative value. By attempting to provide a rational explanation in objective medical terms, based on his understanding of pulmonary functions and the interaction of coal dust with lung tissue, Dr. Fino trips over the *Cornett* court's concern that such an explanation sounds too much like clinical pneumoconiosis. As a result, I conclude that Dr. Fino's explanation has diminished probative value within the jurisdiction of the U.S. Court of Appeals for the Sixth Circuit.

Notably, the *Cornett* decision does not alter my earlier assessment that Dr. Sullivan's opinion stills suffers loss of probative value due to the equivocation associated with his pneumoconiosis diagnosis. As result, although it may be "reasoned," I find Dr. Sullivan's diagnosis due to other concerns does not sufficiently support a finding of pneumoconiosis.

In summary, based on the decision in *Cornett*, and since this case arises within the jurisdiction of the U.S. Court of Appeals for the Sixth Circuit, I ultimately find the conclusion of Dr. Baker that Mr. Newport has legal pneumoconiosis has greater probative value than Dr. Fino's explanation of why Mr. Newport does not have that disease. As a result, in this particular federal appellate circuit, the preponderance of the more probative medical opinion, represented by Dr. Baker's findings, establishes that Mr. Newport's exposure to coal dust was a significant factor in the development of his present pulmonary condition. Accordingly, based on this more probative evidence, Mr. Newport has proven that he has legal pneumoconiosis as defined by 20 C.F.R. §§ 718.201 (a) (2) and (b) (2001), which also means he has undergone a change in condition since the record closed on his claim in November 1998. Having established the presence of legal pneumoconiosis and a corresponding change in condition, Mr. Newport has demonstrated that a modification of the BRB-affirmed denial of his claim may be appropriate. As a result, I must now determine based on the entire record developed since Mr. Newport filed his claim in 1990 whether he is entitled to benefits under the Act.

Issue # 3 – Entitlement to Benefits

As previously discussed, to receive benefits under the Act, Mr. Newport must prove by the preponderance of the probative evidence that he has pneumoconiosis that arose out of his coal mine employment and that he is totally disabled due to coal workers' pneumoconiosis. Returning again to the first element of entitlement, in Mr. Newport's case, he may demonstrate the presence of pneumoconiosis through chest x-ray evidence or probative medial opinion.

Pneumoconiosis

Chest X-Rays

The following table summarizes the other chest x-ray interpretations in the record.

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
December 14, 1984	DX 25a	Dr. Cohen, BCR	Normal

May 16, 1989	DX 180 & DX 96	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD and emphysema present.
(same)	DX 35 & DX 91	Dr. Pendergrass, BCR	Negative for pneumoconiosis. Granulomatous disease.
(same)	DX 84 & DX 104	Dr. Aycoth, B	Positive for pneumoconiosis, profusion category 1/0, type p/s opacities, emphysema.
(same)	DX 84 & DX 104	Dr. Pathak, B	Positive for pneumoconiosis, profusion category 1/2, type p/s opacities, emphysema.
(same)	DX 107	Dr. Robinette, B	Positive for pneumoconiosis, profusion category 1/2, type p/t opacities, pulmonary fibrosis and old granulomatous disease.
(same)	DX 113	Dr. E. Nicholas Sargent, B, BCR	Negative for pneumoconiosis, emphysema and COPD present
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae maybe present
Jan. 28, 1990	DX 180 & DX 82	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD and bibasilar fibrosis present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis, emphysema and bullae present
(same)	DX 81	Dr. Spitz, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 34	Dr. E. Nicholas Sargent, B, BCR	Negative for pneumoconiosis. COPD and emphysema present.
(same)	DX 37, 40 & DX 91	Dr. Pendergrass, BCR	Negative for pneumoconiosis. Healed granulamatous disease present.
(same)	DX 100	Dr. B. Broudy, B	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities[38]
April 18, 1990	DX 180 & DX 96	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD and emphysema present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 35 & DX 91	Dr. Pendergrass, BCR	Negative for pneumoconiosis. Granulamatous disease present
(same)	DX 84 & DX 104	Dr. E. Aycoth, B	Positive for pneumoconiosis, profusion category 1/1, type p/s opacities.
(same)	DX 84 & DX 104	Dr. K. Pathak, B	Positive for pneumoconiosis, profusion category 1/2, type p/s opacities, emphysema.
(same)	DX 107	Dr. Robinette, B	Positive for pneumoconiosis, profusion category 1/2, type q/t opacities, calcified granulomas, emphysema and bullae.
(same)	DX 114	Dr. E. Nicholas Sargent, B, BCR	Negative for pneumoconiosis. Emphysema and COPD present
Nov. 13, 1990	DX 180 & DX 29	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD, interstitial fibrosis, bullae and emphysema present.
(same)	DX 15	Dr. T. Cohen, BCR	Negative for pneumoconiosis. Bullous present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.

[38]Dr. Broudy did not believe his finding of profusion category 1/0 represented a diagnosis of coal workers' pneumoconiosis. Rather, he characterized his finding as nonspecific, since the opacities could be related to a variety of diseases or conditions. However, since his reading complies with ILO standards, it represents a finding of pneumoconiosis. His concern about etiology becomes relevant in the consideration of the second element of entitlement, pneumoconiosis related to coal mine employment.

(same)	DX 28, DX 44 & DX 65	Dr. Spitz, B, BCR	Negative for pneumoconiosis.
(same)	DX 37, DX 40 & DX 91	Dr. Pendergrass, BCR	Negative for pneumoconiosis. Healed granulamatous disease present.
(same)	DX 100	Dr. B. Broudy, B	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities.[39]
Jan. 16, 1991	DX 180 & DX 29	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD, interstitial fibrosis, bullae and emphysema present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 13	Dr. Goldstein, B	Completely negative for pneumoconiosis.
(same)	DX 16	Dr. T. Cohen, BCR	Negative for pneumoconiosis, bullae present
(same)	DX 28, DX 44 & DX 65	Dr. Spitz, B, BCR	Negative for pneumoconiosis.
(same)	DX 37, DX 40, & DX 91	Dr. Pendergrass, BCR	Negative for pneumoconiosis. Healed granulamatous disease present.
(same)	DX 100	Dr. B. Broudy, B	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities.[40]
April 22, 1991	DX 180	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 33, DX 40, & 91	Dr. Pendergrass, B, BCR	Negative for pneumoconiosis. Emphysema, bullae, mild granulamatous disease present.
(same)	DX 65	Dr. Spitz, BCR, B	Negative for pneumoconiosis. Bullae formation and interstitial fibrosis present.
(same)	DX 103	Dr. T. Cohen, BCR	Negative for pneumoconiosis. Bullae and COPD present
(same)	DX 100	Dr. B. Broudy, B	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities.[41]
May 1, 1991	DX 180 & DX 29	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD, interstitial fibrosis, bullae and emphysema present.
(same)	DX 27	Dr. Ahmed, B, BCR	Positive for pneumoconiosis, profusion category 1/1, type p/p opacities, emphysema.
(same)	DX 27	Dr. E. Aycoth, B	Positive for pneumoconiosis, profusion category 2/1, type p/t opacities.
(same)	DX 14	Dr. E. Nicholas Sargent, B, BCR	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities.
(same)	DX 28, DX 44, & DX 65	Dr. Spitz, B, BCR	Negative for pneumoconiosis.

[39] *Id.*

[40] *Id.*

[41] *Id.*

(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 37, DX 40 & DX 91	Dr. Pendergrass, BCR	Negative for pneumoconiosis. Infiltrates consistent with pneumonia present.
(same)	DX 100	Dr. B. Broudy, B	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities.[42]
August 20, 1991	DX 83 & DX 93	Dr. Spitz, B, BCR	Negative for pneumoconiosis. Bullae and emphysema present.
(same)	DX 85	Dr. Wiot, B, BCR	Negative for pneumoconiosis. Bullae and emphysema present.
(same)	DX 85 & DX 100	Dr. B. Broudy, B	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities, interstitial change and scattered calcified granulomas.[43]
(same)	DX 103	Dr. T. Cohen, BCR	Negative for pneumoconiosis. Bullae and COPD present
Oct. 2, 1991	DX 180 & DX 82	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD and bibasilar fibrosis present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 41	Dr. L. Westerfield, B	Positive for pneumoconiosis, profusion category 2/1, type q/t opacities, granulamatous calcifications present
(same)	DX 65 & DX 81	Dr. Spitz, B, BCR	Negative for pneumoconiosis. Bullae formation and interstitial fibrosis present
(same)	DX 100	Dr. B. Broudy, B	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities.[44]
Oct. 11, 1991	DX 40 & DX 91	Dr. Pendergrass, BCR	Negative for pneumoconiosis. Parenchymal scarring present.
(same)	DX 38 & DX 46	Dr. Hudson	Negative for pneumoconiosis. Emphysema, interstitial fibrosis.
(same)	DX 47 & DX 51	Dr. K. Mathur, B, BCR	Positive for pneumoconiosis, profusion category 1/2, type p/s opacities
(same)[45]	DX 63, DX 95, DX 104 & DX 105	Dr. Aycoth, B	Positive for pneumoconiosis, profusion category 1/0 and 1/1, type p/q opacities
(same)	DX 67 & DX 104	Dr. Pathak, B	Positive for pneumoconiosis, profusion category 1/2, type p/q opacities, emphysema and present
(same)	DX 71 & DX 85	Dr. Wiot, B, BCR	Negative for pneumoconiosis. Interstitial fibrosis, bullae and emphysema present.
(same)	DX 72, 85 & DX 93	Dr. Spitz, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.

[42] *Id.*

[43] *Id.*

[44] *Id.*

[45] Dr. Aycoth presented two slightly different interpretations of this chest x-ray. Both were positive for pneumoconiosis and are counted as one physician's opinion.

Feb. 12, 1992	DX 180	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 65 & DX 81	Dr. Spitz, B, BCR	Negative for pneumoconiosis. Granulamatous calcifications present.
(same)	DX 85 & DX 100	Dr. B. Broudy, B	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities, interstitial change and scattered calcified granulomas[46]
(same)	DX 103	Dr. Blanks	Negative for pneumoconiosis. Bullae, scattered interstitial fibrosis and COPD present.
October 5, 1992	DX 83 & DX 93	Dr. Spitz, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)[47]	DX 85	Dr. Wiot, B, BCR	Negative for pneumoconiosis. Emphysema present
(same)	DX 103	Dr. T. Cohen, BCR	Negative for pneumoconiosis. COPD and bullae present.
Sept. 12, 1994	DX 109	Dr. Robinette, B	Positive for pneumoconiosis, profusion category 1/0, type p/s opacities, calcified granulomas present
(same)	DX 109	Dr. Mullens	Chronic interstitial change and pulmonary hyperinflation consistent with pulmonary disease present.
(same)	DX 110	Dr. Shipley, B	Positive for pneumoconiosis, profusion category 1/2, type s/s opacities, consistent with interstitial lung disease[48]
(same)	DX 112	Dr. Spitz, B, BCR	Negative for pneumoconiosis. Bullae, emphysema, kerley lines and COPD present.
(same)	DX 120	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema present.
(same)	DX 120	Dr. Scott, B, BCR	Negative for pneumoconiosis. Emphysema and scattered non-specific fibrosis present.
Jan. 9, 1997	DX 152	Dr. Shipley, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities[49]
March 27, 1997	DX 180	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD present.
(same)	DX 141	Dr. Wiot, B, BCR	Negative for pneumoconiosis. Bullae and emphysema present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.

[46]*See* FN 38.

[47]The x-ray is dated October 2, 1992 but referred to by Dr. Wiot, in his deposition testimony as the October 5, 1992 film.

[48]Although Dr. Shipley indicated the presence of pneumoconiosis under ILO standards, he did not believe the chest x-ray showed coal workers' pneumoconiosis.

[49]*Id.*.

(same)	DX 187	Dr. Fino, B	Negative for pneumoconiosis. Pulmonary fibrosis present.
April 18, 1997	DX 180	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD present.
(same)	DX 141	Dr. Wiot, B, BCR	Negative for pneumoconiosis. Bullae and emphysema present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 187	Dr. Fino, B	Negative for pneumoconiosis. Pulmonary fibrosis present
June 19, 1997	DX 180	Dr. Wiot, B, BCR	Negative for pneumoconiosis. COPD present.
(same)	DX 141	Dr. Wiot, B, BCR	Negative for pneumoconiosis. Bullae and emphysema present.
(same)	EX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
(same)	DX 187	Dr. Fino, B	Negative for pneumoconiosis. Pulmonary fibrosis present.
Feb. 24, 1998	DX 152	Dr. R. Shipley, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities, bullae and emphysema present[50]
(same)	DX 153	Dr. Spitz, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
June 22, 1998	DX 152	Dr. Shipley, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities, and finds bullae and emphysema present[51]
(same)	DX 153	Dr. Spitz, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present.
July 24, 1998	DX 152	Dr. Shipley, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities, bullae and emphysema present[52]
(same)	DX 153	Dr. Spitz, B, BCR	Negative for pneumoconiosis. Emphysema and bullae present
Aug. 24, 1998	DX 152	Dr. Shipley, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities, emphysema and mild interstitial fibrosis present[53]

Of these chest x-rays, there is no dispute regarding seven of the films. The physicians who reviewed the December 14, 1984, October 5, 1992, March 27, 1997, April 18, 1997, and June 19, 1997 films uniformly found them to be insufficient for a diagnosis of pneumoconiosis. As a result, I find these five chest x-rays do not establish the presence of pneumoconiosis. The physicians who reviewed the January 9, 1997 and August 24, 1998 x-rays uniformly found them to be positive for pneumoconiosis. As a result, I find those two x-rays positive for pneumoconiosis.

[50] *Id.*

[51] *Id.*

[52] *Id.*

[53] *Id.*

The remaining chest x-rays generated an interpretation dispute among the reviewing physicians. Dr. Wiot, Dr. Sargent, and Dr. Wheeler, dual qualified radiologists, and Dr. Pendergrass, a board certified radiologist, did not observe the presence of pneumoconiosis in the May 16, 1989 film; however, Drs. Aycoth, Pathak and Robinette, all B-readers, found the x-ray positive for pneumoconiosis. The courts and Benefits Review Board have determined that it is proper to give greater probative weight to the interpretation of a dual qualified radiologist in comparison to a physician who is only a B reader. *Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003), *Cranor v. Peabody Coal Co.,* 22 B.L.R. 1-1 (1999) (en banc on recon.) and *Sheckler v. Clinchfield Coal Co.,* 7 B.L.R. 1-128 (1984). Consequently, I give the negative interpretation of the better qualified doctors greater probative weight than the opinions of the B readers who reviewed this film. The May 16, 1989 chest x-ray is negative for pneumoconiosis.

In the January 28, 1990 chest x-ray, Dr. Broudy, a B reader, found the presence of pneumoconiosis in the x-ray; Drs. Wiot, Wheeler, Spitz, and Sargent, all dual qualified radiologists, did not. Dr. Pendergrass, a board certified radiologist agreed with the consensus that the x-ray was negative for pneumoconiosis. Therefore, the preponderance of the medical opinion by five better qualified physicians regarding the presence of pneumoconiosis in the January 28, 1990 film is negative. As a result, I find the January 28, 1990 chest x-ray to be negative for the presence of pneumoconiosis.

In a similar manner, Drs. Wiot, Wheeler and Sargent, all dual qualified radiologists, in addition to Dr. Pendergrass, a board certified radiologist, found the April 18, 1990 x-ray to be negative for the presence of pneumoconiosis; whereas Drs. Aycoth, Pathak and Robinette, all B readers, found the film to be positive for pneumoconiosis. Again, the opinion of the dual qualified physicians is more persuasive. The April 18, 1990 x-ray is negative for the presence of pneumoconiosis.

For the same reasons, the November 13, 1990 film is negative for the presence of pneumoconiosis. The preponderance of the medical opinions by Drs. Wiot, Wheeler, and Spitz, all dual qualified readers, along with Dr. Pendergrass, a board certified radiologist, outweigh the sole positive finding of pneumoconiosis by Dr Broudy, who is a B reader. Therefore, the November 13, 1990 film is negative.

The January 16, 1991, April 22, 1991, August 20, 1991, October 2, 1991, and February 12, 1992 films are negative for the presence of pneumoconiosis. The negative findings by six qualified physicians outweigh the sole contrary finding of pneumoconiosis by Dr. Broudy in the January 16, 1991 x-ray. The negative findings by five qualified physicians outweigh the sole contrary finding of pneumoconiosis by Dr. Broudy in the April 22, 1991 x-ray. The negative findings by three qualified specialists outweigh the sole contrary finding of pneumoconiosis by Dr. Broudy in the August 20, 1991 x-ray. The negative findings by three dually qualified physicians, Drs. Wiot, Wheeler and Spitz, outweigh the contrary findings of Dr. Broudy and Dr. Westerfield, both B readers, in the October 2, 1991 film. Finally, the negative findings by Drs. Wiot, Wheeler and Spitz, along with Dr. Blanks, who possesses no special training for reading x-rays, outweigh the sole contrary finding of Dr. Broudy in the February 12, 1992 film.

Concerning the May 1, 1991 film, Drs. Wiot, Spitz, and Wheeler, dual qualified radiologists, along with Dr. Pendergrass, a board certified radiologist did not find the presence of pneumoconiosis; however, Drs. Ahmed, Sargent, dual qualified radiologists, in addition to Drs. Aycoth and Broudy, B readers, found the film to be positive for pneumoconiosis. Since the preponderance of the dual qualified radiologists considered this film to be negative, I conclude the May 1, 1991 chest x-ray does not show the presence of pneumoconiosis.

The October 11, 1991 film also presents a closer question. Dr. Mathur, a dual qualified radiologist, and Drs. Aycoth and Pathak, both B readers, found the presence of pneumoconiosis; whereas Drs. Wiot and Spitz, dual qualified radiologists, Dr. Pendergrass, a board certified radiologist, and Dr. Hudson, who is not specially trained in radiology, did not. Among the most qualified physicians, the consensus of Dr. Wiot and Dr. Spitz that the film is negative prevails over the contrary positive assessment by Dr. Mathur. As s result, the October 11, 1991 chest x-ray is negative for pneumoconiosis.

In the September 12, 1994 film, Dr. Robinette and Dr. Shipley, B readers, found the presence of pneumoconiosis; Drs. Spitz, Wheeler, and Scott, dual qualified radiologists, did not. Dr. Mullens did not assess the x-ray for pneumoconiosis. Therefore, the preponderance of the interpretations by similarly qualified radiologists is negative for the presence of pneumoconiosis. Accordingly, the September 12, 1994 film is negative.

Finally, Dr. Shipley, a B reader, found the ILO presence of pneumoconiosis in the February 24, 1998, June 22, 1998, and July 24, 1998 chest x-rays; whereas Dr. Spitz, a dual qualified radiologist, did not. Based on his better qualifications, Dr. Spitz's opinion prevails. The February 24, 1998, June 22, 1998 and July 24, 1998 x-rays are negative for the presence of pneumoconiosis.

In summary, combining my previous determination that the ten most recent chest x-rays from November 2000 through February 2003 do not support a finding of pneumoconiosis with the above assessment of the other radiographic images of Mr. Newport's lungs that are contained in the record, I continue to conclude that the overwhelming majority of the chest x-rays are either negative or inconclusive for the presence of pneumoconiosis. Accordingly, Mr. Newport is unable to establish the presence of pneumoconiosis in his lungs through radiographic evidence under 20 C.F.R. § 718.202 (a) (1) (2001).

Medical Opinion

Since Mr. Newport was able to establish a change in condition in the form of legal pneumoconiosis based on the most recent, and therefore, relevant medical opinion concerning the present condition of his lungs, and considering the progressive nature of pneumoconiosis,[54] the medical assessments contained in the record prior to November 1998 which were insufficient

[54] *See* 20 C.F.R. § 718.201 (c).

to demonstrate the presence of pneumoconiosis have little relevant probative value. However, for the purpose of completeness, I have summarized these earlier opinions.[55]

Dr. Charles Wender
(DX 25A)

Dr. Wender evaluated Mr. Newport's risk for coronary artery disease on July 20, 1981. He opined that Mr. Newport was in no immediate distress but his smoking history of 1 ½ packs of cigarettes per day for 20 years put him at risk.

Dr. William Swann
(DX 33 and DX 103)

Dr. Swann conducted a pulmonary examination of Mr. Newport on October 11, 1988. Mr. Newport presented with a history of smoking 1 ½ packs of cigarettes per day for 20 years. The physician noted that Mr. Newport had a history of COPD, emphysema, coughing, wheezing, sputum production and chest tightness. Dr. Swann concluded that Mr. Newport had a moderate obstructive defect based on a pulmonary function test.

Dr. Swann examined Mr. Newport again on December 13, 1988. He stated that Mr. Newport had a coal mine employment history of 27 years as a truck driver and again complained of productive cough, wheezing, night sweat, and chest tightness. Dr. Swann diagnosed COPD.

Dr. Ronald Pack
(DX 31)

Dr. Pack examined Mr. Newport primarily for reasons unrelated to his pulmonary condition in September 1989, however he noted that Mr. Newport had a history of COPD. He also found hyperinflation of the chest and scattered granulomas in a chest x-ray.

Dr. Roswell Beck
(DX 30)

Dr. Beck conducted a medical examination of Mr. Newport on October 5, 1990 and October 12, 1990. He diagnosed COPD and dyspnea.

Dr. L.J. Seargeant
(DX 10 and DX 68)

On November 13, 1990, Dr. Seargeant conducted an examination of Mr. Newport. Mr. Newport presented with a 28 ½ year coal mine employment history, mostly as a truck driver transporting coal and a smoking history of 38 years at the rate of one pack of cigarettes per day,

[55]I have not summarized a medical report from Dr. Hanna dated January 16, 1997 that is not related to Mr. Newport's pulmonary condition (DX 140). Additionally, I have not included notations from Dr. Young, Dr. Crutchfield, Dr. Vinson and Dr. Stitcher regarding conditions unrelated to Mr. Newport's pulmonary health (DX 103).

stopping in 1987. He complained of cough, sputum, wheezing and dyspnea. After having conducted medical examinations of Mr. Newport on a few occasions and treating him for upper respiratory infections, Dr. Seargeant concluded that Mr. Newport had an abnormal x-ray but did not have COPD or pneumoconiosis on April 18, 1991. Subsequently, on May 28, 1991, Dr. Seargeant reviewed medical records, which included physical examination reports, chest x-rays and pulmonary function test results. Dr. Seargeant opined that the chest x-rays and pulmonary function tests produced abnormal results. The physician found lung pathology but not pneumoconiosis and noted possible cancer of the lung.

Dr. Joseph Smiddy
(DX 41)

Dr. Smiddy, board certified in internal medicine and pulmonary disease, conducted a pulmonary examination of Mr. Newport on October 2, 1991, who presented with a productive cough since 1988, shortness of breath, wheezing and chest pain. Mr. Newport had a coal mine employment history of 28 years as a truck driver transporting coal and 2 ½ years in the coal preparation plant. Mr. Newport smoked 1 ½ packs of cigarettes per day for 35 years. Dr. Smiddy diagnosed Mr. Newport with significant coal workers' pneumoconiosis based on chest x-rays and noted a moderate restrictive defect with underlying COPD based on the results of a pulmonary function test.

Dr. A. R. Hudson
(DX 38 and DX 46)

Dr. Hudson, board certified in internal medicine and pulmonary disease, conducted a pulmonary examination of Mr. Newport on October 11, 1991. Mr. Newport presented with a history of chronic lung disease, cough, shortness of breath, wheezing and chest pain. Mr. Newport had a coal mine employment history of 23 ¾ years and a 34 year smoking history. The physician diagnosed chronic obstructive bronchitis and emphysema, finding a moderate obstructive defect based on pulmonary function test results. Chest x-rays suggested the presence of interstitial pathology, but not in a pattern consistent with coal workers' pneumoconiosis.

In a deposition conducted on April 3, 1992, Dr. Hudson expanded on his findings regarding his examination of Mr. Newport in October 1991. He stated that the x-ray showed emphysema with large bullae and scarring. The pulmonary function test results showed a significant obstructive defect and the arterial blood gas study showed moderate hypoxemia. Dr. Hudson concluded that Mr. Newport suffered from chronic obstructive bronchitis and emphysema. He opined that Mr. Newport could drive a truck but could not change tires or load the truck manually. Dr. Hudson also noted that although he was unaware of how many cigarettes per day Mr. Newport smoked, when asked hypothetically whether a smoking history as significant as 1 ½ packs of cigarettes per day would affect his findings, he reiterated his diagnosis of emphysema and not coal workers' pneumoconiosis.

Dr. Harold Spitz
(DX 85)

In a deposition conducted on March 25, 1993, Dr. Spitz, a dual qualified radiologist, explained that after reviewing a number of Mr. Newport's chest x-rays from January 1990 through October 1992, he found no evidence of coal workers' pneumoconiosis, but did see COPD, bullae and septal lines. He also opined when asked hypothetically that if a patient smoked 1 ½ packs of cigarettes per day for 30 years, the patient would have a smoking history significant enough to cause COPD.

Dr. Jerome Wiot
(DX 85)

In a deposition conducted on March 25, 1993, Dr. Wiot, a dual qualified radiologist, reiterated his findings regarding a number of chest x-rays of Mr. Newport taken between January 1990 and October 1992. Dr. Wiot found no evidence of coal workers' pneumoconiosis but cited the presence of emphysema and bullae formation consistent with pulmonary fibrosis. When asked hypothetically whether his findings would be consistent with a person who smoked 1 ½ packs of cigarettes per day for over 30 years, he believed they would. Moreover, when asked hypothetically how a coal mine employment history of 23 years as a truck driver transporting coal would impact his findings, he stated that his findings would not be different because the pulmonary problems he found in Mr. Newport were consistent with cigarette smoking, not coal dust exposure.

Dr. Bruce Broudy
(DX 85 and DX 100)

Dr. Broudy, board certified in internal medicine and pulmonary disease, conducted two medical record reviews in August 1992, one consisting only of chest x-rays, and a subsequent review in which he examined other medical evidence. Dr. Broudy concluded, after assuming Mr. Newport had a coal mine employment history significant enough to cause impairment, that his findings were not consistent with coal workers' pneumoconiosis. Rather, Mr. Newport appeared to be potentially afflicted by asbestos; however, the physician did not believe that Mr. Newport had ever been exposed to asbestos. Though Dr. Broudy found opacities, his findings were non-specific and do not mean that occupational dust exposure caused the abnormalities.

Dr. Broudy further explained his findings regarding Mr. Newport through deposition testimony, after reviewing more x-rays and medical reports on April 13, 1993. He made a finding of profusion category 1/0 opacities but stated that this was a nonspecific finding, not necessarily indicative of coal workers' pneumoconiosis, and could have been caused by chronic bronchitis or something else. Dr. Broudy found that Mr. Newport has an obstructive airway disease causing a significant respiratory impairment that most likely arose from cigarette smoking.

Dr. E. Robinette
(DX 109)

Dr. Robinette, board certified in internal medicine and pulmonary disease, conducted a pulmonary examination of Mr. Newport on September 12, 1994. Mr. Newport presented with a chronic cough, shortness of breath, wheezing, dyspnea and a 28 ½ year coal mine employment history as a truck driver. Mr. Newport smoked at least 1 pack of cigarettes per day, stopping in 1988, resulting in at least 40 pack years. A physical examination of Mr. Newport's chest revealed an increase in chest diameter. Dr. Robinette found interstitial pulmonary fibrosis. Pulmonary function test results showed a moderately severe obstructive lung disease. The physician diagnosed coal workers' pneumoconiosis with underlying pulmonary emphysema with response to bronchodilation and severe obstructive pulmonary disease. Mr. Newport's progressive airflow obstruction was consistent with bronchitis and coal workers' pneumoconiosis. He was totally disabled from a respiratory standpoint, and this impairment was at least partly related to coal dust exposure.

Dr. Thomas A. Sullivan, Jr.
(DX 140, DX 148, DX 149, DX 150, and DX 158)

I have previously summarized Dr. Sullivan's 1997 and 1998 treatments of Mr. Newport. At that time, Dr. Sullivan had diagnosed chronic obstructive bronchitis, emphysema, and coal workers' pneumoconiosis.

In summary, most of the physicians to consider Mr. Newport's pulmonary condition from 1981 through 1998 only diagnosed COPD, unrelated to coal dust exposure. However, that dated consensus is outweighed by the preponderance of the more probative, recent medical opinion in the form of Dr. Baker's evaluation that establishes Mr. Newport now has a coal dust-related pulmonary impairment. Accordingly, I find Mr. Newport has proven the presence of legal pneumoconiosis through medical opinion under 20 C.F.R. §718.202 (a) (4) (2001).

Pneumoconiosis Arising Out of Coal Mine Employment

Once a claimant has proven the existence of pneumoconiosis, 20 C.F.R. § 718.203 (a) (2001) requires that he also establish that his pneumoconiosis arose at least in part from his coal mine employment. According to 20 C.F.R. § 718. 203 (b) (2001), if the claimant was employed in coal mining for ten or more years, a rebuttable presumption that the pneumoconiosis is due to coal mine employment exists.

As I previously determined, Mr. Newport has over 27 years of coal mine employment. Consequently, he is entitled to the presumption that his pneumoconiosis is related to his coal truck driving. Extensive evidence exists in the record that points to cigarette smoking rather than coal dust as the cause of Mr. Newport's obstructive impairment. However, I have already determined that through the most recent and probative opinion of Dr. Baker, Mr. Newport has proven that his obstructive pulmonary defect is related in part to coal dust exposure. No evidence exists that his coal dust exposure which has now affected his breathing occurred at

some other time than when he was driving coal to the preparation plant. As a result, I find Mr. Newport's legal pneumoconiosis is due to his coal mine employment.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. § § 718.204 (b) (2001) and 718.304 (2001). If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2) (2001), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Newport has not presented evidence of cor pulmonale with right-sided congestive heart failure and the record contains no evidence of complicated pneumoconiosis. As a result, Mr. Newport must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests[56]

Exhibit	**Date / Doctor**	**Age / Height**	**FEV_1 pre[57] post[58]**	**FVC pre Post**	**MVV pre post**	**% FEV_1 / FVC pre post**	**Qualified[59] pre Post**	**Comments**
DX 31	Sept. 11, 1989	57	2.3	3.5		66%	No[60]	

[56]I am not including a pulmonary function test conducted on June 22, 1998 because the form in the record appears incomplete, and does not contain the name of the physician who conducted the test or the miner's age and height.

[57]Test result before administration of a bronchodilator.

[58]Test result following administration of a bronchodilator.

[59]Under 20 C.F.R. § 718.204 (b)(2)(i) (2001), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

	Dr. Pack	67″						
DX 32 & DX 103	Oct. 18, 1989 Dr. Swann	57 69″	1.88	3.32	71	57%	Yes[61]	Moderate obstruction
DX 30	Oct. 6, 1990 Dr. Beck	58 71″	1.97	2.95	54.3	67%	Yes[62]	
DX 8	Nov. 13, 1990 Dr. L. J. Seargeant	59 69″	1.63	3.06	61.8	53%	Yes[63]	
DX 41	Oct. 2, 1991 Dr. Smiddy	59 70″	1.59	3.20	62	50%	Yes[64]	
DX 38	Oct. 11, 1991 Dr. A. Hudson	59 68″	1.71 1.86	3.56 4.09	73 86	48% 45%	Yes[65] Yes	
DX 109	Sept. 12, 1994 Dr. Robinette	62 69″	1.30 1.63	3.11 3.89	60	42% 42%	Yes[66] Yes	
DX 140 & DX 149	Jan. 9, 1997 Dr. Sullivan	65 68”	1.52 1.60	3.48 4.09	59 68	44% 39%	Yes[67] Yes	Severe obstruction
DX 140 & DX 149	April 18, 1997 Dr. Sullivan	65 68″	1.14	2.46		46%	Yes	
DX 176	Jan. 19, 2001[68] Dr. Baker	69 67″	1.35	2.97		45	Yes	Valid per Dr. Michos (DX 176)
DX 177	Mar. 13, 2001 Dr. Sullivan	69 68″	1.26	2.92		43	Yes	Valid per Dr. Michos

[60]The qualifying FEV_1 number is 1.95 for age 57 and 68.1″; the corresponding qualifying FVC and MVV values are 2.48 and 78, respectively.

[61]The qualifying FEV_1 number is 2.01 for age 57 and 68.9″; the corresponding qualifying FVC and MVV values are 2.56 and 81, respectively.

[62]The qualifying FEV_1 number is 2.15 for age 58 and 70.9″; the corresponding qualifying FVC and MVV values are 2.74 and 86, respectively.

[63]The qualifying FEV_1 number is 1.98 for age 59 and 68.9″; the corresponding qualifying FVC and MVV values are 2.52 and 79, respectively.

[64]The qualifying FEV_1 number is 2.08 for age 59 and 70.1″; the corresponding qualifying FVC and MVV values are 2.64 and 83, respectively.

[65]The qualifying FEV_1 number is 1.92 for age 59 and 68.1″; the corresponding qualifying FVC and MVV values are 2.44 and 77, respectively.

[66]The qualifying FEV_1 number is 1.93 for age 62 and 68.9″; the corresponding qualifying FVC and MVV values are 2.47 and 77, respectively.

[67]The qualifying FEV_1 number is 1.82 for age 65 and 68.1″; the corresponding qualifying FVC and MVV values are 2.34 and 74, respectively.

[68]Because the tracings were not attached to the test results, the reliability of the January 19, 2001 ventilatory study is questionable, and I may discredit it for that reason. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). Additionally, because it was conducted on or after January 19, 2001, the flow-volume loop is required to be admitted into the record. 20 C.F.R. §718.103(b) (2001).

								(DX 177)
DX 175 & DX 176	April 27, 2001 Dr. Baker	69 67″	1.39	3.65		38	Yes	Moderate obstruction. Valid per Dr. Michos (DX 176)
CX 9	May 13, 2002 Dr. Sullivan	70 68″	1.36	3.13		43	Yes	Severe obstruction / reduction of diffusion
CX 6	Feb. 19, 2003 Dr. Baker	71 67.25″	1.33	3.09		43	Yes	Moderate obstructive defect
CX 1	Feb. 20, 2003 Dr. Narayanan	71 69″	1.17	2.78	50.5	42	Yes	Severe obstruction

Under the provisions of 20 C.F.R. §718.204 (c) (1) (2001), if the preponderance of the pulmonary function tests qualify under Appendix B of Section 718, then in the absence of evidence to the contrary, the pulmonary function test evidence shall establish a miner's total disability.

In terms of contrary evidence, the arterial blood gas studies as set out below indicate that despite his obstructive breathing defect, Mr. Newport is able to sufficiently oxygenate his blood such that the oxygen levels do not fall below the total disability standards.

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest) pO^2 (exercise)**	**Qualified[69]**	**Comments**
DX 33	Oct. 11, 1988 Dr. Swann	41.3	65.8	No[70]	
DX 33	Nov. 18, 1989 Dr. Swann	41.4	81	No	
DX 11	Nov. 13, 1990 Dr. L.J. Seargeant	44 41	72 76	No No	
DX 41	Oct. 2, 1991 Dr. Smiddy	38.7	77	No[71]	
DX 38	Oct. 11, 1991 Dr. Hudson	39.8	69	No	
DX 104	Sept. 12, 1994 Dr. Robinette	40.1	67	No	
CX 6	Feb. 19, 2003	39	72	No[72]	

[69]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[70] For the pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

[71] For the pCO^2 of 39, the qualifying pO^2 is 61, or less.

[72] For the pCO^2 of 39, the qualifying pO^2 is 61, or less.

	Dr. Baker				

As he well knows, and the qualifying pulmonary function tests clearly demonstrate, Mr. Newport has struggled with a moderate to severe pulmonary obstruction for years. Since the arterial blood gas studies and the pulmonary function tests measure different types of disability (*See Tussey v. Island Creek Coal Co.* 982 F. 2d 1036, 1040-41 (6th Cir. 1993)), the arterial blood gas studies do not necessarily impeach a finding of total disability based on pulmonary function tests. Additionally, although the blood gas studies did not reach disabling levels, almost all of the physicians who examined Mr. Newport and considered both the pulmonary function tests and the blood gas studies, nevertheless diagnosed a significantly disabling obstructive pulmonary impairment. Mr. Newport's duties as a coal truck driver required the occasional expenditure of heavy labor to change truck tires and clear frozen coal from the truck bed. The physicians' opinions, as supported by the numerous qualifying pulmonary function tests, conclusively establish that Mr. Newport is no longer capable of such heavy labor and can not return to his work as a coal truck driver. Accordingly, the preponderance of the medical opinion and qualifying pulmonary function tests outweigh the contrary medical evidence and prove Mr. Newport is totally disabled due to his chronic obstructive pulmonary disease.

Total Disability Due to Coal Workers' Pneumoconiosis

Because Mr. Newport has established three of the four requisite elements for entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to coal workers' pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Under 20 C.F.R. § 718.204 (c) (1) (2001), absent regulatory presumptions in favor of a claimant,[73] the claimant must demonstrate that pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: 1) had a material, adverse effect on his respiratory or pulmonary condition; or, 2) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204 (c) (2) (2001) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report."

And so I return to the issue of reasoned medical opinion and the relative probative weight of the opinions of Dr. Baker, Dr. Sullivan, and Dr. Fino, the three physicians in the best position to determine Mr. Newport's present respiratory impairment. According to Dr. Baker, the primary, or at least equal to cigarette smoke, cause of Mr. Newport's pulmonary impairment was his coal dust exposure. In September 2001, Dr. Sullivan agreed that one of the few factors causing Mr. Newport's impairment was "certainly" his exposure to coal dust. Dr. Fino indicated that even if Mr. Newport impairment was caused in part by coal dust, its contribution to the pulmonary impairment was negligible in comparison to the lung damage caused by cigarette smoke.

---

[73]20 C.F.R. § 718.305 (2001) (if complicated pneumoconiosis is present, then there is an irrebuttable presumption the claimant is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (2001) (for claims filed before January 1, 1982, if the miner has fifteen years or more of coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and, 20 C.F.R. § 718.306 (2001) (a presumption exists when a survivor files a claim prior to June 30, 1982).

In assessing the relative probative weight of these opinions, I first note that Dr. Fino opined Mr. Newport had neither clinical nor legal pneumoconiosis. Nevertheless, he also expressed a causation opinion that if pneumoconiosis were present, it would have little impact on Mr. Newport. Perhaps ironically, due to his detailed explanation on why Mr. Newport does not have pneumoconiosis, Dr. Fino has little rationale left upon which to base his disability causation opinion other than his actual belief that Mr. Newport does not have pneumoconiosis. However, since that belief is contrary to my determination that Mr. Newport does have legal pneumoconiosis, Dr. Fino's disability causation assessment has little relative probative value.

Dr. Sullivan's equivocation on the presence of pneumoconiosis also undermines his causation determination. In light of the last three most recent treatment notes, which do not include a diagnosis of pneumoconiosis, I am unable to ascertain whether Dr. Sullivan still believes in his September 2001 statement that pneumoconiosis is materially and adversely affecting Mr. Newport's pulmonary capacity.

Dr. Baker was fairly definite about the connection between Mr. Newport's obstructive pulmonary defect and his exposure to coal dust. Yet, as stated above, since the regulations require that pneumoconiosis, even legal pneumoconiosis, have a material, adverse effect on, or materially worsen, a claimant's pulmonary capacity, I am troubled by the absence of an explanation by Dr. Baker on how he determined that Mr. Newport's pneumoconiosis was a significant factor in his pulmonary impairment. Once again the court in *Cornett* has indirectly addressed that concern. In *Cornett,* while remanding the case without addressing the adjudication principles for this last entitlement element, the court stated in discussing and upholding the sufficiency of the pneumoconiosis diagnoses by Dr. Vaezy and Baker:

> Both doctors also stated that Cornett was totally disabled, meaning he was unable to continue the strenuous work in the mines. They noted, however, that it was impossible to determine the extent to which Cornett's smoking history contributed to his respiratory problems. They were both clear, however, that exposure to coal dust was a "significant factor" in causing Cornett's moderate respiratory impairment (emphasis added). *Cornett*, 227 F.3d at 572.

In other words, even though the physicians indicated that they were unable to determine the extent of disability causation between cigarette smoke and coal dust, the court still found their causation assessments viable since they were presented with clarity. In Mr. Newport's case, Dr. Baker's conclusion on the cause of his disability is just as clear. Accordingly, in this federal court of appeals jurisdiction, Dr. Baker's unexplained statement that coal dust has played a significant role in Mr. Newport's breathing problems establishes that his respiratory disability is due to legal coal workers' pneumoconiosis.

CONCLUSION

Based on the probative opinion of Dr. Baker, Mr. Newport has established that he has legal pneumoconiosis, which represents a change in his physical condition that warrants reconsideration of the entire record. Based on that review, I conclude that through Dr. Baker's

assessment and the preponderance of pulmonary function tests, Mr. Newport has proven that he is totally disabled due to legal coal workers' pneumoconiosis. Accordingly, his claim for disability benefits under the Act must be approved.

Augmentation

Benefits under the Act may be augmented for a person who meets the criteria of spouse under 20 C.F.R. § 725.204 and the dependency requirements of 20 C.F.R. § 725.205 (2001). Based on the parties stipulation of fact, I find that Mrs. Geneva Newport is a qualified spouse and meets the regulatory requirements for spousal augmentation of Mr. Newport's black lung disability benefits.

Date of Entitlement

Under 20 C.F.R. § 725.503 (d) (2) (2001), in the case of a coal miner who receives an award of disability benefits through a change of conditions under 20 C.F.R. § 725.310, benefits are payable beginning the month of onset of total disability provided no benefits are payable for any month prior to the effective date of the most recent denial of the claim by the administrative law judge. If the evidence does not establish the date of onset of total disability, then benefits are payable beginning the month the claimant requested modification.

Based on that guidance, three dates need to be established. First, in Mr. Newport's case, Judge Tureck finally denied his second modification request/claim in June 1999. Second, Mr. Newport filed his third modification request and submitted additional medical evidence in January 2001. Third, since I have principally relied on Dr. Baker's medical opinion, the record indicates that by the time of Dr. Baker's first evaluation of Mr. Newport on November 4, 2000, he was totally disabled due to legal pneumoconiosis.[74] At the same time, the record is insufficient to determine when the date of onset occurred between Judge Tureck's denial in June 1999 and Dr. Baker's first diagnosis in November 2000. Accordingly, I conclude that Mr. Newport is entitled to black lung disability benefits as of November 1, 2000.

[74] *See Tobrey v. Director, OWC*P, 7 B.L.R./ 1-407, 1-409 (1985) (at best, the date of examination indicates that some time prior to the examination, total disability onset occurred).

ORDER

The claim of Mr. ELDON K. NEWPORT for benefits under the Act is **GRANTED**. The Employer, OLD DOMINION COAL CORPORATION, is ordered to pay Mr. ELDON K. NEWPORT all benefits to which he is entitled under the Act and Regulations. Benefits shall commence November 1, 2000.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: April 7, 2004
Washington, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481 (2001), any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 (2001) and § 725.479 (2001). A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1

American Board of Medical Specialties

Certification:

Gurpreet K. Narula, MD

Certified by the American Board of Internal Medicine in:

Internal Medicine

American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201-5913
Phone Verification: (866) ASK-ABMS
Phone: (847) 491-9091/FAX: (847) 328-3596

HTTP://abms.org